Original NEMSAC Bucket List of Ideas and Activities to Discuss

Bucket 1 of 8*

Administration - Structure/System

- Organization and integration of air medical services
- There's no universal method for EMS systems inventory & workload nationwide
- Absence of governmental responsibility and accountability to assure provision of EMS
- Standardized response time expectation/performance measures
- Standardized definitions and performance measures, but not standardized response times – will vary widely by type of service, location, etc.
- System fragmentation
- Enhanced coordination between state Highway Safety and EMS Offices
- Integration of regionalized, accountable, and coordinated systems of Pediatric Emergency Care
- Assessing differences in EMS systems by configuration; clinical capability
- NTSB-style oversight of EMS agency crashes
- Access to trauma systems
- Integrating with other community systems
- Emergency department overcrowding, patient diversion
- System redesign in rural/frontier & austere settings
- There needs to be a lead Federal EMS agency
- Mechanisms for immediate interstate legal recognition
- No pervasive performance improvement systems transparent and accessible to all
- Interface: integration with other health, public health partners.
- Joint planning with public health and health care agencies, prophylaxis for first responders including families, integration of GIS, patient tracking.
- Information sharing across EMS agencies across different cities/states/countries, the possibility of sending people to other services for a week or two, this might be nice as a nationally sponsored program.
- Some sort of online application that would house lessons learned, protocols, templates, after action reports, etc, kind of like LLIS, with some sort of security built in.
- EMS role in regional systems of care -trauma, STEMI, stroke, peds, ob
- Consider different types of providers for rural EMS such as expanded scope of practice for existing health professionals, such as community health aid.
- *Establish model systems for both rural EMS and urban EMS with guiding principles, core issues and operational plans*

* *Italics* indicate areas in which NEMSAC committees have made previous progress. There may have been further progress made by other national groups or federal agencies.

Bucket 2 of 8

Finance - Funding/Billing

- Medicare reimbursement – pay for performance & what it means for EMS
- Base reimbursement on performance standards not transport and readiness for defined geographical areas
- *EMS reimbursement in general – currently emphasis is on taking patient to hospital since that is the only way to be reimbursed. Should focus more on cost of readiness, prevention programs, treat/release, and perhaps even transport to other health care settings besides ER (health clinic, etc.)*
- Equitable access to federal grants for EMS agencies, including private/non-profit EMS providers that do emergency work
- Funding for medical oversight
- Adequate funding for personnel, infrastructure, equipment from non-reimbursement sources
- Adequate financial support for research
- Money for EMS infrastructure
- Medicaid funding
- Funding source to rebuild EMS infrastructure
- Defined and adequate benefit assurance (third-party payments)
- Recognize and support readiness costs
- Provide reimbursement for non-transports

Bucket 3 of 8

Human Resources- Education, Certification, Workforce and Safety

- Interstate credentialing and licensing, including how to handle volunteers at major incidents
- Ensure equitable access to accredited education programs – geographic, financial, etc.
- *Standardized certification, licensure and credentialing of personnel, agencies and systems*
- Adopt the "5-part model" (EMS Education Agenda for the Future) and it's influence /effect on initial education, national certification, and improving reciprocity
- Staffing resource capabilities both for day-to-day and surge
- Recruitment and retention of increasingly professional staff
- Leadership development
- Pay and benefits for EMS personnel
- Safety of EMS personnel
- *Safety of personnel – include vehicle design, lighting, conspicuity, lifting/transfer devices, protection from exposure, highway safety, driver training*
- Recruiting young people, getting parental support
- Keeping training and performance requirements within reach of the volunteers;
- Mechanisms for immediate interstate legal recognition

- EMT/Paramedic injuries/wellness and mental health readiness (pre and post)
- Recruitment, but I would recommend focusing not only on young people, but also people who would make the job a career and stay for the long haul.
- Some sort of online application that would house lessons learned, protocols, templates, after action reports, etc, kind of like LLIS, with some sort of security built in.
- Minimum Standard EVOC programs

Bucket 4 of 8

Operations and Equipment

- Communications systems, interoperability
- There needs to be some method to evaluate the efficacy and performance of new devices
- Lack of operational systems integration

Bucket 5 of 8

Public Education and Information

- Public education and information
- Promoting recognition among the public of the importance of EMS
- Public expectations exceed actual EMS/911 capacity
- Leveling public recognition and appreciation for EMS compared to other public safety services

Bucket 6 of 8

Research, Technology, and Data

- Better standardization and collection of EMS related data points
- EMS participation in Health Information Enterprise
- Institutional Review Boards & EMS research
- Data; belief and ownership and compliance (NEMSIS)
- A nationwide EMS crash database with common data points to collect/study the problem
- Mapping/GIS/Data Analysis
- CAD to CAD interfaces for quickly sharing information
- Emergency medical Dispatch/Wireless 9-1-1/Voice over Internet Protocol (VOIP)
- Vehicle crash telematics – AACN
- Some sort of online application that would house lessons learned, protocols, templates, after action reports, etc, kind of like LLIS, with some sort of security built in.
- Support electronic patient care records to allow for 100% case review

Bucket 7 of 8

Medical Oversight and Quality

- Clarification/standardization of when it is appropriate to call for helicopter transport
- Application of advanced QI
- Standardized response time expectation/performance measures
- EMS QI programs should have some sort of peer review protections that hospitals have – this will encourage more "no fault" reporting of incidents and near misses to identify/fix system issues
- Standardized definitions and performance measures, but not standardized response times – will vary widely by type of service, location, etc.
- Medical oversight
- Physicians should have more oversight of standards – for example, a physician should be able to determine what type of response and response time goals are medically appropriate for a system.
- Sub-specialization for EMS MDs
- *Patient safety and medical errors*
- No pervasive performance improvement systems transparent and accessible to all
- Place an emphasis on interventions which "make a difference" rather than concentrating on response time standards
- Create EMS protocols which are evidence-based and seamless between First response and Transport

Bucket 8 of 8

Disaster Preparedness

- Emergency Preparedness – national recommendations for training, planning, resources, stockpiling, as well as alt standards of care, might be helpful, not to mention a national EMS EP grant.
- Regionalize protocols, equipment and medical oversight, etc. for disaster response