NATIONAL EMS MANAGEMENT ASSOCIATION

Inspired Leaders Serving Their Communities

June 30, 2016

Gamunu Wijetunge
Office of Emergency Medical Services
National Highway Traffic Safety Administration
United States Department of Transportation
1200 New Jersey Avenue SE – West Building Room W12-140
Washington, DC 20590

RE: Comments for Docket No. NHTSA-2016-0035

Dear Mr. Wijetunge.

The National Emergency Medical Services Management Association (NEMSMA) is pleased to provide comments on the proposed revision to the Emergency Medical Services (EMS) Agenda for the Future solicited via a Request for Information issued on 4/1/2016. NEMSMA is an organization that has come into being since the publication of the EMS Agenda for the Future in 1996 and represents the management and leadership of EMS organizations from across the United States regardless of organizational type. In preparation of these comments we actively polled our membership regarding their concerns and appreciate your consideration of our perspective as this project moves forward. In response to your specific questions:

1. What are the most critical issues facing EMS systems that should be addressed in the revision of the EMS Agenda? Please be as specific as possible.

   Our association identified a number of common themes regarding critical issues facing EMS systems including:

   - Identity of Emergency Medical Services / Paramedicine

     The 1996 agenda listed the following as an implicit assumption; "**EMS represents the intersection of public safety, public health, and healthcare systems.** A combination of the principles and resources of each is employed be EMS systems." (p. 4) The 2006 Institute of Medicine document *Emergency Medical Services at the Crossroads* reiterated and modified this concept to say, "EMS operates at the intersection health care, public health, and public safety and therefore has overlapping roles and responsibilities. Often, local EMS systems are not well integrated with any of these groups and therefore they receive inadequate support from each of them. As a result, EMS has a foot in many doors but no clear home." (p. 29)

     This characterization of EMS as a part of other disciplines may be the most critical issue facing EMS. A revised agenda must define a unique domain of EMS. Furthermore, revisions to the agenda must recognize our past conceptualizations while acknowledging the growth and development of EMS systems and the evolution of paramedicine as profession. Overall, we must define a place of our own.

- Inadequate financing at multiple levels

  A coherent discussion regarding the appropriate financing of EMS systems has yet to occur in the 50 years that EMS has been in existence and was inadequately addressed in the 1996 agenda. As noted EMS is regularly described as the intersection of public safety, healthcare and public health, however, this characterization leads to a fragmented view of EMS. Public safety, public health and healthcare are financed by completely different mechanisms in the United States adding to the confusion around appropriate funding of EMS systems. As a result, EMS has suffered from the absence of a comprehensive financial strategy. The most influential discussion of EMS financing was held in 2000 as part of the Ambulance Fee Schedule Negotiated Rulemaking Process conducted by the agency now known as the Centers for Medicare and Medicaid Services (CMS). While it is unlikely and unnecessary for EMS to be funded through a solitary mechanism, a discussion regarding funding requirements, responsibilities of various payers, and the comprehensive measurement of value is long overdue. The absence of a common understanding of EMS financing is contributing to the ongoing failure of EMS systems to meet current and future community needs.

- Paramedicine fails to meet the standard of a health profession.

  While significant strides have been made in the education and credentialing of EMS practitioners in the past 20 years, they do not measure up to the standards of other health professions which leaves our workforce inadequately prepared to undertake the increasingly diverse and complex roles our society will demand of them. Furthermore, parochial concerns have locked our practitioners into low paying vocational – technical occupations with little or no opportunity for career growth. While the ongoing need to supply entry-level (EMR & EMT level) practitioners is clear, our corresponding failure to require college degrees for our top tier professionals (paramedics and specialized paramedics) is an unacceptable disservice to both the patients we serve and our providers who are called to make EMS a career.

- Failure of EMS organizations to take a leading role in shaping the future of EMS

  EMS in particular, and the profession of paramedicine more generally, has been the ongoing victim of benevolent paternalism. Modern EMS as a concept was envisioned by a government document in 1966. Our state regulatory systems were created by federal funding provided by the EMS Act of 1973, and the physician community has been instrumental to our development at every turn. Furthermore, many state and national EMS credentialing and advisory bodies are populated by individuals and organizations external to, or only tangentially related to, EMS delivery. While the evolution of this situation has been well-intentioned, the development of paramedicine as a self-determined and self-regulating profession has been significantly inhibited. As many of our international colleagues have learned, the professional practice of paramedicine must be led by professionals in our field and should not be the burden of the government or the physician community to bear. To achieve status as a legitimate health profession, the path to the future must be forged primarily by EMS organizations and paramedicine professionals in cooperation with, not at the direction of, our historic enablers.

- Failure to adequately integrate EMS with the broader healthcare system

  The United States faces unprecedented healthcare challenges in the next 30 years. EMS is seldom mentioned in the broader context of health system integration and reform. Historically, EMS has evolved in a piecemeal fashion to address a collection of issues including, highway deaths, cardiac care, trauma, resuscitation, etc. To this day, EMS is mostly recognized as a supplier of transportation services and did not even get a footnote in the Patient Protection and Affordable Care Act or 2010. Efforts in areas such as electronic patient care reporting, paramedic specialization, community paramedicine and the development of EMS as a physician subspecialty have helped bridge this gap, however, much work remains to be done as EMS continues largely disconnected from the acute care, primary care, home health, public health and behavioral health communities.

- Inadequate non-clinical, administrative and systems-related research

  The 1996 agenda was largely successful in promoting and supporting EMS clinical research and made progress in building relationships with academic research institutions. Advances based on research in the areas of resuscitation, pediatric care, trauma care, and airway management have been profound. What remains, however, is research in non-clinical areas of EMS such as finance, system design, safety, leadership, education, effectiveness and public policy development. Substantial progress in these areas will require a significant increase in undergraduate and graduate level EMS programs as well as the development of funded research programs, partnerships with institutions of higher education, and suitable publication outlets that do not yet exist.

- Unrealized potential of information systems

  The National EMS Information System (NEMSIS) was one of the earliest data standards in the healthcare sector and electronic EMS patient care reporting has achieved substantial penetration among EMS services. Unfortunately, the ability of EMS systems, governments and researchers to effectively use the data collected remains limited. EMS services lack information technology and data analysis capability due to funding limitations. Electronic patient care reporting platforms are poorly designed to enhance interoperability, provider workflow and patient safety. Furthermore, practitioners, EMS leaders and policymakers have a limited understanding of data management, privacy requirements, interoperability and research methodology that largely inhibits the effective use and sharing of state and national datasets.

- Limited workforce mobility

  Forty-seven years after the National Registry of EMTs was founded, the adoption of this national entry-level clinical credential remains a patchwork across the county. We are decades past the point where we must embrace a national credentialing program and must take responsibility as professionals to ensure the National Registry of EMTs and similar organizations are integrated and effective servants of both our profession and the public. The REPLICA interstate compact also represents an important effort to enhance provider mobility, however, it remains unrealized awaiting the participation of at least 10 states.

- Disjointed federal, state and local oversight of EMS

  There have been calls for a lead federal agency in EMS for decades including the landmark *Emergency Medical Services at the Crossroads* document published by the Institute of Medicine in 2006. This was also an important recommendation of the 1996 Agenda that was made more apparent after the terrorist attacks of 9/11/01 and the subsequent creation of the U.S. Department of Homeland Security in 2002. To date, no agency has been designated to serve in this capacity, fragmenting EMS issues across the federal government. NHTSA has funded ongoing reviews and re-reviews of state EMS agencies, yet they remain a conglomeration of disparate models. Many state offices remain underfunded, plagued with high turnover, and staffed with limited numbers of career EMS professionals. Local oversight, control and coordination of EMS, where it even exists, is often a minor function assigned as an afterthought to a local government department, or a delegated responsibility to a non-governmental organization with limited authority and resources.

- Ongoing and unproductive internecine conflict

  EMS in the United States is provided by a variety of organizational delivery types vying for supremacy in an environment that will always leave EMS system design decisions to the state or local level. Competition for power, influence and resources by sector-based EMS groups is harmful to local communities and harmful to EMS overall. Patients, who benefit from stable and effective EMS systems regardless of tax-status, staffing model, or delivery type, are often left behind in these ideological, absurd and mostly unresolvable debates about who should provide EMS. This conflict is further exacerbated by the absence of strong professional and academic communities that could advocate for excellence in all models. This dissention fragments policy development, confuses the public, inhibits the development of paramedicine as a profession, and prolongs reliance on flawed regulatory, funding and staffing models.

2. What progress has been made in implementing the EMS Agenda since its publication in 1996?

   Despite the long list of issues and opportunities moving forward, significant strides have been made in the implementation of the 1996 Agenda as well as the goals of the previous EMS Act of 1973. Those accomplishments include:

   - Establishment of an EMS regulatory infrastructure in every state and territory
   - The evolution of community paramedicine
   - Establishment of an EMS clinical research enterprise at a variety of locations
   - Creation of physician fellowship programs in EMS
   - Funding of EMS research by EMS for Children, NHTSA, NIOSH and the NIH
   - Accreditation of paramedic educational programs as a condition of NREMT certification
   - Transition to the National EMS Education Standards
   - Funding of limited ambulance safety and fatigue research
   - Creation of a physician EMS subspecialty and improved training of EMS medical directors
   - Efforts toward national uniformity of 4 EMS provider levels (EMR, EMT, AEMT & Paramedic)
   - Development of the National EMS Scope of Practice Model
   - Development of National EMS Core Content.

- Improved EMS participation in public education activities including social media
- Development of the NEMSIS 3.0 standard
- Ubiquitous access to 9-1-1 via multiple methods
- Significant advancements in communications technology and the creation of FirstNet

3. How have you used the EMS Agenda? Please provide specific examples.

   In requesting comments for this response from our membership it was interesting to discover that the 1996 document was known to some, but completely unfamiliar to others within the EMS leadership community. Those that were familiar with the document were aware of its use as the basis for a variety of EMS educational programs at the undergraduate and graduate level. We are also aware of a number of states that use the elements of the agenda as guidelines for their state, regional and local planning and technical assistance activities. It is also clear that the agenda has been used to advance a number of projects at the national level. Our association in particular, was able to use the conceptual framework of the agenda to produce *EMS Management and Leadership Development in America :An Agenda for the Future*. Overall, we feel strongly that the agenda has served an important basis for initiatives throughout our industry at all levels. It should be updated and maintained.

4. As an EMS stakeholder, how might the revised EMS Agenda be most useful to you?

   NEMSMA would continue to use a revised agenda as a basis to describe the essential elements of an EMS system. We would further work to engage our membership in developing and implementing recommendations for each element. We are currently rolling out an EMS officer credentialing program and would look to include the agenda elements and recommendations in our competencies and credentialing process wherever possible. A revised agenda would also be useful to our members to conduct improvement activities at the state and local levels. A number of our members would also like a future agenda to drive useful grant programs at the national and state levels.

5. What significant changes have occurred in EMS systems at the national, State and local levels since 1996?

   Our members had mixed opinions regarding significant changes in EMS since 1996. Some felt we had made very little measurable progress as an industry with the possible exception of EMS research. Others indicated EMS has become more professional and more clinically sophisticated. Some mentioned increases in call volume and ever increasing demands for EMS systems to do more with less. Along those lines, it is interesting to note that subsequent to the CMS negotiated rulemaking process in 2000 the delivery of EMS has become more financially difficult for many EMS organizations while the same process has simultaneously produced significant proliferation and overcapacity in the air ambulance sector. Other major milestones included the requirement that paramedic programs be accredited and the evolution of paramedic specialization credentials such as the certified flight paramedic (FP-C). Finally, a number of our members mentioned that the events of 9/11/01 had a substantial impact the priorities of the public safety community. While domestic preparedness has substantially improved as a result, it has taken almost a decade for EMS leaders to return their focus to our healthcare mission. Many hope a similar investments of time and resources can now be made on the healthcare aspects of EMS moving forward .

6. What significant changes will impact EMS systems over the next 30 years?

   We seem to be headed towards a future of comparative effectiveness analysis and a value-based payment, however, progress on that front has been limited to date. Based on healthcare cost projections, it appears this is inevitable. This will require that EMS transition from a transportation supplier to a value-based healthcare provider with excellent data systems and seamless integration with other healthcare components. These changes will drive higher standards and services such as community paramedicine. While variable costs will move to this payment model, the issue of covering fixed costs will remain unresolved as it is unlikely that the fixed costs of EMS readiness will be covered through healthcare payment models. It is unclear if a differentiation will develop between EMS organizations solely providing emergency response services, perhaps with volunteers and/or dual-role personnel, and those services that delve deeper into more sophisticated medical care. Regardless, we must be prepared for multiple paths moving forward. We must also be prepared for demographic trends that will produce a huge wave of older Americans that will require EMS care provided by a much smaller generation of new EMS practitioners.

7. How might the revised EMS Agenda support the following FICEMS Strategic Plan goals:

   a. Coordinated, regionalized, and accountable EMS and 9-1-1 systems that provide safe, high-quality care;

   b. data-driven and evidence-based EMS systems that promote improved patient care quality;

   c. EMS systems fully integrated into State, territorial, local, tribal, regional, and Federal preparedness planning, response, and recovery;

   d. EMS systems that are sustainable, forward looking, and integrated with the evolving health care system;

   e. an EMS culture in which safety considerations for patients, providers, and the community permeate the full spectrum of activities; and

   f. a well-educated and uniformly credentialed EMS workforce.

   While this question is extensive, we believe the answer is simple. A revised EMS agenda must support these goals and the revision process must be focused on these objectives at a minimum. FICEMS members must also be in a position to support work on these objectives through appropriate funding mechanisms.

8. How could the revised EMS Agenda contribute to enhanced emergency medical services for children?

   The EMS for Children (EMSC) program has arguably been the most successful and consistent federal program supporting EMS in the past 30 years. This modest federal program has ensured the care of children is addressed at the state level across the United States and EMSC funding has built the most substantial EMS research infrastructure in the country through the strategic support of EMS data

collection, the Pediatric Emergency Care Applied Research Network (PECARN) and Targeted Issues (TI) grants. Our members recognized that pediatric emergency care has improved, however evidenced-based pediatric education remains somewhat limited and/or inaccessible. A revised agenda should support ongoing EMSC efforts. Our association would also point out that EMSC efforts have been targeted to a small subset of pediatric EMS patients, and a more global approach along the same lines could be even more useful.

9. How could the revised EMS Agenda address the future of EMS data collection and information sharing?

   The future of EMS, and more generally the future of healthcare will be dependent on the effective collection and use of data. The 1996 Agenda was largely responsible for building our national data system inclusive of NEMSIS and EMS data programs in the states. While there is a lot of progress to report in this area, some of our members expressed serious concerns that electronic data collection by EMS practitioners had become a "nightmare." It was also noted that the EMS data system exists in a silo whereby EMS records are never connected to a patient's other health records. Additional comments indicated that existing reporting products were poorly designed from a workflow perspective. Complications such as HIPAA, misunderstandings about HIPAA, and state regulations were also referenced as problematic to effective data collection and exchange. The revised agenda must recognize these flaws and work to resolve them through suitable policy recommendations and best practice recommendations lest our data system be relegated to an ineffective and unusable tool that is universally hated by providers.

10. How could the revised EMS Agenda support data-driven and evidence-based improvements in EMS systems?

    Currently the NEMSIS data base is largely inaccessible and unusable to many serious researchers since the national data set is really only useful for the most basic of scoping questions. If data driven decisions are desired this must be addressed, the level and quality of data available must be improved, and appropriate access must be provided in order for the data to be used for serious comparative effectiveness or value analysis purposes.

11. How could the revised EMS Agenda enhance collaboration among EMS systems, health care providers, hospitals, public safety answering points, public health, insurers, palliative care and others?

    Our members would respectfully suggest you also add behavioral health to this list. Our stakeholders also felt that collaboration will be a key element moving forward and that EMS by and large had been left out of many of the mechanisms recently put in place to better integrate care and encourage integration throughout healthcare. The revised agenda must address better integration of EMS into these areas and it was also suggested a federally sponsored EMS innovation center may be useful. Our members also commented that while EMS has made strides in this area, we must be careful to make sure collaboration is not too burdensome, particularly considering the financial and resource constraints discussed earlier. If we're going to collaborate effectively, it must be paid for.

12. How will innovative patient care delivery and finance models impact EMS systems over the next 30 years?

    This is a great question our association wishes we could answer. What we do know is that EMS finance models are failing, rely far too heavily on cost shifting, and are largely built on unrealistic expectations that EMS can continue to be provided at no or little cost to the taxpayer. It is unclear if any recent innovations, particularly community paramedicine, will be sustainable over time. Considering all of this, we can certainly expect significant changes and it would be ideal if a revised agenda can help point us in the proper direction.

13. How could the revised EMS Agenda promote community preparedness and resilience?

    This is an interesting question and perhaps a fine example of where, for political reasons, EMS gets pulled into a topic that is more appropriately addressed in another realm. Our membership feels strongly that this topic is more appropriate for our partners in the emergency management community. Our role as EMS is to ensure our services are prepared and resilient. Sufficient capacity does not currently exist for EMS to play anything other than a minor supporting role in community preparedness activities. If a revised agenda wishes to address this area, significant resources will need to be identified that can probably be better utilized elsewhere.

14. How could the revised EMS Agenda contribute to improved coordination for mass casualty incident preparedness and response?

    As has been seen in multiple disasters since the writing of the 1996 agenda, EMS is largely unprepared, often barely has the resources to meet day-to-day needs, and receives a pittance of the funding directed at preparedness and response despite having an important role. Most EMS organizations have little or no staff dedicated to this type of preparedness and coordination. This area was left out of the 1996 agenda and must be addressed in any future revisions.

15. How could the revised EMS Agenda enhance the exchange of evidence based practices between military and civilian medicine?

    Since the wars in Afghanistan and Iraq, significant knowledge has been exchanged between the military and civilian medical communities. EMS has benefitted in many areas of clinical practice, especially hemorrhage control. It appears this knowledge transfer has been mostly informal, so a revised agenda could improve efforts in this area.

16. How could the revised EMS Agenda support the seamless and unimpeded transfer of military EMS personnel to roles as civilian EMS providers?

    A national EMS provider certification has existed through the National Registry of EMTs since 1973. Both the Department of Defense and the states are at fault for failing to incorporate and recognize this existing standard. Military medics returning from the Vietnam War were instrumental in the birth of our profession and the fact that we can't facilitate this transition 50 years later is rather embarrassing. A revised agenda should make strong recommendations to resolve this issue as legislative and regulatory efforts to date have failed to address the core issues within the military and state regulatory agencies.

17. How could the revised EMS Agenda support interstate credentialing of EMS personnel?

    As mentioned previously, EMS workforce mobility will continue to be a major concern, particularly as demands for more EMS practitioners due to demographic shifts create and exacerbate personnel shortages. While significant progress is currently being made, particularly in terms of the REPLICA model legislation, a revised agenda must be used as a tool to further encourage adoption of national standards (i.e. NREMT and IBSC) by the states. Many of our members have already expressed concern about workforce shortages that are likely to get worse. The balance will be maintaining an adequate supply of entry level technicians while simultaneously increasing the knowledge base and standards for our upper level clinicians.

18. How could the revised EMS Agenda support improved patient outcomes in rural and frontier communities?

    The 1996 agenda was a catalyst to the development of the *Rural and Frontier EMS Agenda for the Future* in 2004. This document, among other accomplishments, was responsible for further developing the community paramedicine concept. Much like the original agenda, however, work remains to be done to implement these recommendations and update the vision to improve care in rural communities. Incentives also need to be developed to encourage regionalization of EMS systems where economies of scale are inadequate to support effective and professional delivery of EMS. To date, the term regionalization has only been applied to the coordinated treatment of certain clinical conditions or patient populations. Future efforts in this area are required and should continue to be done in collaboration with rural health partners to ensure EMS remains available and viable throughout rural America.

19. How could the revised EMS Agenda contribute to improved EMS education systems at the local, State, and national levels?

    EMS suffers because paramedicine is not a health profession by any comparable standard. Our members have commented repeatedly that multiple opportunities have been missed since 1996 to finally require a post-secondary degree for at least our top tier of professionals and that federal and other efforts must be targeted at paramedicine degree development. Parochial interests and lack of political will are likely responsible for this ongoing situation. A revised agenda must discuss this issue.

    Additional issues exists in that we fail to educate and credential specialists in our profession in a coherent manner and there is a substantial gap in education and training for EMS managers and leaders.

    The good news is we have done great work getting to the National EMS Education Standards and requiring CoAEMSP accreditation. The job now is to move our educational systems to the next level through degree requirements. We must also assure that we have mechanisms in place to develop qualified EMS educators and faculty for initial certification and higher education programs. Simultaneously, at the EMR and EMT levels we need to continue to ensure technical education is accessible at these levels to ensure all communities have the ability to provide some level of EMS services.

20. How could the revised EMS Agenda lead to improved EMS systems in tribal communities?

    Our association received no comments on this item and we have no members indicating a tribal EMS affiliation. In concept, we encourage participation of tribal EMS within their regional EMS systems and welcome future collaboration opportunities with Native American EMS providers and the Indian Health Service (IHS) where applicable.

21. How could the revised EMS Agenda promote a culture of safety among EMS personnel, agencies and organizations?

    EMS safety issues have gained prominence in the past twenty years. The previous agenda made only cursory mention of occupational health research, however our industry has taken on a number of safety issues ranging from ambulance design standards and fatigue through medication safety and provider wellness. The EMS culture of safety document, although led by a group external to EMS, has helped define EMS safety concerns. Unfortunately, only limited safety research has been done, and safety reporting systems remain fragmented and largely unused. While much work remains to be done, revisions to a future agenda will both lend structure to and help prioritize important future work in this area and will further support fledgling efforts to develop an EMS safety credential by the IBSC. Future work should take into account work already in progress by the National EMS Safety Council and others and work towards strengthening safety related reporting systems in EMS. We can also look to external documents such as the Institute of Medicine's *To Err is Human* , the Just Culture movement, and international safety documents, standards and research.

22. Are there additional EMS attributes that should be included in the revised EMS Agenda? If so, please provide an explanation for why these additional EMS attributes should be included.

    EMS integration into Homeland Security including such topics as surge capacity, disaster preparedness, mass casualty response, active shooter response, terrorism awareness and response and EMS continuity of operations were not addressed in the 1996 agenda and have clearly proven to be important areas of focus. An element focusing on EMS and Homeland Security is a necessary addition to any future agenda.

23. Are there EMS attributes in the EMS Agenda that should be eliminated from the revised edition? If so, please provide an explanation for why these EMS attributes should be eliminated.

    Over the past twenty years the definitions of and boundaries between public education, prevention, public access and communications have become blurry. As such, our association has the following thoughts on these categories for your consideration:

    A. EMS has taken on a role much larger than just prevention in public health. EMS involvement in emerging disease planning, surveillance and response have all emerged as important EMS roles. Community paramedicine programs have also expanded the footprint of EMS substantially in many areas such as behavioral health access and community-based care. As such we would recommend expanding the current prevention element to a broader category of public health which will hopefully also increase understanding among our community of the diverse range of public health activities while maintaining the primary and secondary aspects of prevention in the EMS mission.

B. Public Access and Communications can probably be combined as communications technologies have evolved such that it is difficult to isolate particular components of how individuals access emergency services and how we communicate amongst ourselves and with others. Landline phones, texting, mobile phones, secure apps, global positioning systems, trunked radio systems, etc. are now all part of a communications landscape that did not exist in 1996. A revised agenda should combine these two topics into a more robust communications element.

C. Finally, we believe public education may also have outgrown its original categorization. In order for EMS to be effective we must have an informed public at all levels, we must engage them regularly through social media and other channels, and their experience of care, a component of the IHI triple aim, must be elevated. As such we would recommend the Public Education element be re-envisioned as Stakeholder Engagement and Customer Experience.

24. What are your suggestions for the process that should be used in revising the EMS Agenda?

The 1996 agenda project was conceived of and led by state EMS regulators and the EMS physician community under the direction of the federal government. A careful read of the document will reveal that issues important to state EMS offices and medical directors were well covered. While we recognize the important and historic contributions of the federal government, state officials and physicians to the development of EMS, and certainly respect their role as essential collaborators, the future of EMS must finally begin to be shaped by those who do it.

As noted previously, our biggest challenges moving forward relate to professional development, finance, workforce issues and safety. As such, we expect to see an EMS professional organization, or a group of professional organizations, such as those involved in the recent EMS 3.0 white paper, take the lead on this project from the perspective of EMS providers, leaders and/or educators. Furthermore, we would expect the project's contractor would be very familiar with the delivery of EMS, be well respected within our professional community and would represent more than a single segment of the EMS community.

We would also point out that EMS in the United States, particularly on the professional development front, has been eclipsed by other international systems such as those in Canada, Europe and Australia. In particular, we would point to documents such as *The Future of EMS in Canada: Defining the New Road Ahead* published by the Paramedic Chiefs of Canada in 2006 and The Australian College of Ambulances Professional's *Enhancing Patient Outcomes* published in 2011 as other excellent models we can look to as we move forward.

25. What specific agencies/organizations/entities are essential to involve, in a revision of the EMS Agenda?

Our association believes the following organizations are essential participants in a revised agenda process

- National EMS Management Association (NEMSMA)

- International Paramedic (IP)
- National Association of Emergency Medical Technicians (NAEMT)
- National Association of EMS Educators (NAEMSE)
- National Association of State EMS Officials (NASEMSO)
- National Association of EMS Physicians (NAEMSP)
- National Registry of EMTs (NREMT)
- International Board of Specialty Certification (IBSC)
- Federal partners that represent the Federal Interagency Committee on EMS (FICEMS) stakeholders
- American Ambulance Association (AAA)
- International Association of Fire Chiefs – EMS Section (IAFC)

NEMSMA would also point out that that National EMS Advisory Council (NEMSAC) was created after the 1996 EMS Agenda was written and represents an excellent mechanism to assure that various stakeholder interests are represented at the federal level. We would hope this group could play a significant role in the process of developing an updated agenda.

We recommend that as the process proceeds we involve i groups related to, but not part of EMS. We would welcome the participation of groups that may be able to make important contributions from academia, law enforcement, hospitals, health insurance providers, communications officers, public health, patient advocates and local government organizations and associations. We would be pleased to help identify such groups.

26. Do you have any additional comments regarding the revision of the EMS Agenda?

    May the force be with us!

Thank you again for the opportunity to comment on this important process and we look forward to participating further as the revision process proceeds.

Sincerely,

Michael Touchstone, B.S., Paramedic
President