FEA"TURED ARTICLE

the

ADVOCACY

of US

FEATURED CONTENT
EMS-FTEP: WHAT’S DIFFERENT, AND WHY YOUR AGENCY SHOULD CONSIDER IT
SOLVING INTEROPERABILITY & HIGH-UTILIZER ISSUES IN THE COMMUNITY

Julota is a patented, award-winning community interoperability platform, built on the four pillars of interoperability, compliance, consent, and collaboration. The cloud-based SaaS platform manages the consent and multidirectional sharing of PHI (personal health information) and PII (personally identifiable information) between software systems for healthcare, EMS, law enforcement, behavioral health, social services, and all other local nonprofit and for-profit organizations.

Currently, the care continuum is divided into silos of communication in most communities. These silos operate on unique software built specifically for their users’ needs and many users do not want to replace them with yet another completely new system. In addition, each of these sectors has its own compliances that must be adhered to along with databases of information that need

But imagine if behavioral health could work with their patients through other agencies that deal with them on a day-to-day basis in crisis situations, where they are able to observe their triggers firsthand.

And what if EMS could connect low-acuity patients to appropriate care (rather than just transporting to the ED) in order to prevent them from deteriorating into an acute or chronic condition?

And what if law enforcement could connect individuals to case managers who could prevent unnecessary incarceration and address the underlying issues? This is already happening through co-responder programs around the country.

And finally, imagine if payers start reimbursing the entire care community like they are doing now in pilot projects and will in the future at the federal level through programs like ET3?
This kind of networking is lowering costs and improving healthcare right now in 150 different communities using Julota. But now take a step back and consider what would happen if you enlarge that local network beyond EMS, behavioral health, social services, law enforcement, and healthcare.

Imagine connecting food banks into that same network to address food insecurities...

And getting Catholic Charities and other faith-based organizations to address loneliness in the elderly and home improvement needs...

And connecting fire departments to do fall risk assessments to prevent broken hips...

And enlisting medical and non-medical rideshare services to get people to appointments...

And connecting Home Advisor or Angie’s List to provide free home repair estimates...

And in times of Silver Alerts and disasters, sending out simultaneous messages to at-risk individuals and their family and non-family caregivers to make sure they are safe and have their medical dependencies addressed, decreasing the need for door-to-door searches.

Once all that happens, then you really have a safety net that keeps people from falling through the cracks and supports community-based solutions, which is the most efficient and cost-effective way to address population health.

To see if Julota is right for your MIH-CP program reach out to:
Kevin Amell  |  Business Account Manager  |  719.424.8523  |  kevin@julota.com
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THE BENEFITS OF IMPLEMENTING A COLLEGE DEGREE REQUIREMENT FOR EMS

WHY THE DEGREE DEBATE SHOULDN’T BE A DEBATE ANYMORE

PARAMEDICS NEED DEGREES, AND PUBLIC SAFETY NEEDS A VOCATIONAL ENTRY POINT FOR ALS PROVIDERS

DO PARAMEDICS NEED DEGREES? YES, BUT WHAT KIND?

A DEGREE OF CONCERN

DEGREES FOR NEW PARAMEDICS SHOULDN’T BE THE NEW STANDARD
Of Biometrics & Imagination

A Fresh Take on Patient ID

JONATHON S. FEIT
MBA, MA

Anyone who follows my social media feeds knows that these days I live – for all intents and purposes – at the Delta Sky Club (the airline’s airport lounge). It’s what happens when you achieve Platinum status (75,000 miles yearly) by April.

Want to guess how I get into the club? Fingerprint.

This year I had an exciting mission: to visit each of our partner-clients across 26 states. My trajectory is looking good, and sprinkled into those inspiring meetings are presentations on prehospital technology to Fire & EMS agencies from the Northwest to the Southeast of our fine nation.

Our industry is in the midst of what we MBAs call a “rotation” … where the old phases out, the new phases in, and we all get to wonder what comes next. And yet, there persists a silly mentality out in the world that “an ePCR is an ePCR.”

An argument is still being made that one vendor must own an entire ecosystem (Hello, Delaware! Hello, Maryland!) because companies “don’t play nicely” … so the only way to ensure reliable data is to homogenize the information input. This is nonsense.

Rather than technology, what seems to be missing (most of all) when it comes to telemedicine and the patient side is the information input. One renowned technology solution provider recently advanced a position that headcount growth is perfectly expected five years ago.

As a technologist, I spend about half my time in EMS and fire data; the rest on the hospital side of the handoff. It took me a while to remember that the reason for questions about faxes and lookups is that not every agency has experienced (dare I say “enjoyed”) even a modern set of technical basics.

Some EMS agencies find we still have them... they train the information input... and this fellow has been profoundly unsure whether (or why) he was asked to use biometrics...

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Some EMS agencies find we still have them... they train the information input... and this fellow has been profoundly unsure whether (or why) he was asked to use biometrics...
MRNs (medical record numbers). The only “edge” case we would have to build exceptions for is the truly rare patient without a finger, a toe, or an eye.

The first time the use-case was presented to me, it was by the former chief of a small fire district near the Mexican border. Many of the town’s residents are undocumented, speak only Spanish, and get paid in cash on Friday evenings. Therefore, many weekends featured calls to a small cadre of inebriated foreign language speakers.

So, why not use a fingerprint scanner to query their past data, precisely as Delta Air Lines looks up whether I am allowed to enter the Sky Club?

No need to connect to immigration or justice databases: the hardware is simple enough that almost every cell phone now uses biometric scanners (including facial recognition). Delta uses it to determine whether or not I get to drink in its lounge while I write this article!

Why is EMS not using such “advanced” technologies in the field to slash documentation time and improve continuity of care? The answer to this very time-expensive question is simple, yet profound when you consider the power that your agency has but does not use to get what it needs: EMS agencies have not yet demanded that ePCR vendors deliver substantial innovation.

Agencies should flex their imaginations, whiteboard their wish lists, and not only challenge but demand that vendors deliver everything they need – realizing that pushing innovation forward will save time (and therefore) money in the long run.

I copied a phrase from my friend Jonathan Bush, former CEO of the electronic health records company AthenaHealth. He used to say, “There is a better way.” My version of the phrase is “better is possible.” But this is true only if fire and EMS agencies hold companies accountable and refuse to accept the same tired and old stuff.

JONATHON S. FEIT, MBA, MA, is a Managing Consultant of the BrainTrust of Fire & EMS Technologists, as well as the co-founder & chief executive of Beyond Lucid Technologies, Inc., the company behind the MEDIVIEW ePCR and BEACON Prehospital Health Information Exchange. He’s a contributor to multiple EMS publications on the topics of data sharing, patient care reporting, and technology, and is an experienced journalist outside of the EMS arena as well.
Fatigue in EMS is a significant concern – from an operations & safety perspective.

In both the emergency and inter-facility service models, we have round-the-clock obligations to the communities, patients, and customers served. Inadequate reimbursement and short staffing make meeting these challenges harder; and for most American EMS providers, the answer is long-hour shifts ... 24s, 36s, 48s, and even longer shifts are common answers (and have become what most employees expect).

However, these long-hour shifts flirt with the edges of human performance & safety; and as demands on EMS increase, we are setting our crews, our communities, and our patients up for disaster.

From the perspective of safety, most EMS agencies are not high-reliability organizations.

The history of fatigue management regulation is written in the blood of accident victims. Until 1938, there were no federal regulations regarding fatigue, and it was common for truckers to drive for days in order to deliver their loads, resulting in many collisions and deaths. The ICC’s regulations, enforcement, and powers were limited by the culture & infrastructure of the time and were enforced unevenly, but the groundwork for commercial transport-operator fatigue mitigation was laid and reinforced by state laws.

Today, the NTSB holds fatigue management as one of the greatest hazards to Americans in the course of transportation. \(^{(1)}\) This isn’t just a regulatory opinion, it is the conclusion of many, many academic studies \(^{(2)}\) which correlate fatigue with impairment equivalent to alcohol intoxication.

It isn’t just truckers. The aviation industry also requires pilots to rest between flights and places strict limits on how long pilots can fly and perform other work. This, too, has proven inadequate, as shown by the 2009 Colgan Air 3407 crash. \(^{(3,4)}\) Fifty people died because of inappropriate pilot reactions to an in-flight emergency ... exacerbated by pilot fatigue.

Reading the New York Times article discussing the investigation is particularly enlightening – the sequence of events described and crew behavior prior to the accident could be lifted word-for-word from an EMS crew room. \(^{(5)}\) How many of us habitually work twenty-alternate-hour days, multi-tasking and overworking before going home for a better or rest? If any
combined they event circled on their flight plan not more than one hour before takeoff. (That’s why the NTSB says we shouldn’t even have a rest break policy. We’d harm track the history of fatigue management and accidents from the past.)

We’d better track this and discuss these recommendations to their organizations and declare it (or react to it) as a reaction, ensuring that a policy may be either proactive (a crew recognizes a fatigued state and declares it) or reactive, ensuring that a policy is written in the blood of accident victims.

In particular, the “rest break” policy suggested is problematic. Some organizations have a voluntary fatigue call-out, which may or may not require supervisor approval. This may be either proactive (a crew recognizes a fatigued state and declares it) or reactive, ensuring that a policy is written in the blood of accident victims.

Other small fixes, like encouraging caffeine consumption to see more!... or routine. Even in the military, fatigue is managed 24 hours a day, 7 days a week – even in the field. However, these long-hour shifts flirt with the edges of human performance & safety; and as demands on EMS increase, we are setting our crews, our communities, and our patients up for disaster.

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collaborations between agencies to ensure employees are not going from shift to shift, education of partners in fatigue mitigation, etc.

The consequences of failing to act effectively are not only measured in lives, dollars, and trust, but in public regulation. Eventually, some unfortunate crew, patient, and/or other person(s) will die in a fatigue-induced accident that will garner public attention ... and changes that are not necessarily appropriate for our particular circumstances will be forced upon us. Doing the hard work needed to systemically eliminate life-threatening fatigue is the job of leaders and will mitigate the risk of excess regulation in the future.

We should strive to build high-reliability organizations ... not simply rely upon luck to prevent tragedies.

ROBERT MARTIN, MHA, NRP, is a Nationally Registered Paramedic currently living & working in Texas as a field paramedic. He is passionate about operational improvements, mentorship of new EMTs & Paramedics, and encouraging safe practices.

What words of advice would you offer to someone who wants to build their voice, reputation, and recognition within EMS?

Never, never, never be bullied into silence. Never allow yourself to be made a victim by others or circumstances. Accept no one’s definition of your career by always looking for ways to help others and our profession.

CHARLES | Virginia

Offer more value than you are taking in return.

WESTON | Texas

Firmly believe in your skills, interests ... and never sacrifice your personal and professional credibility. Never become judgmental, but instead, become informed. Work to exceed others’ expectations as a habit and doors & opportunities will come to you.

DANIEL | New York

Medical knowledge isn’t limited by scope of practice.

BRETT | Idaho

As you advance, don’t fall into the “us and them” mentality. We are one team, with different responsibilities. Everything you do should be to ensure the providers have the tools they need and that the patients are getting the care they deserve.

NATE | Georgia

Stand by your words. Your word is your bond. If someone cannot trust your word, should they trust you?

CHRISTOPHER | North Carolina

Don’t pretend to know everything. Stay humble and willing to learn ... and most of all, stay current. Research your position on a topic and ensure science bears it out before you’re stuck on it.

RICHARD | Georgia

It’s all about the customer! Master your craft to serve the customer.

SEAN | California

Start speaking at conferences. Voice, reputation, and recognition are all to be had. Have a specialty niche, plus all other attributes mentioned in previous comments. Be informed, thoughtful, and authentic. Be adaptable when new science emerges.

JULIANNE | Texas
SPACE is somewhat of a “hot commodity” in EMS. Whether it’s your med bag, overhead compartment, or first response bag, there’s only so much equipment that will fit into the available space that you have ... so why not stock it with something that keeps this in mind?

Micro BVM, through its line of Pocket BVM products, offers EMS crews a compact option to an otherwise bulky issue. In a sense, they’re offering a BIG impact ... in a micro way.

Let’s take a step back and talk operations ... logistics ... for a moment.

Whether your agency runs 911 calls, dabbles into interfacility transfers, staffs special events, or even has the occasional off-road response, you’ve got resuscitation equipment located in a number of places for your crews to access.

One bag-valve mask device is located in your primary response bag, another is in your airway cabinet, then there’s your bike team bag, search & rescue bag, and even your MCI kits. Each one of these spaces has their own opportunities ... as well as challenges ... for equipment storage.

You value equipment that offers versatility in terms of its placement, ease-of-use, and universally-recognized packaging that catches the eyes of your responders ... regardless of where its located.

There’s no big & bulky plastic bags, no torn packaging, and no need to shuffle other equipment around in order to simply fit this device inside of your compartment ... it’s micro for a reason!

PRODUCTS:
Pocket BVM
BVM with O2 Tubing
Pocket BVM Tactical
Med bag - fits right next to your airway roll
Bike bag - fits in any side or top compartment
Tactical kit - fits in a thigh pouch
MCI bag - fits in nearly any space
1% of calls require a BVM ... yet, many crews carry a BVM into their scene for 100% of their calls.

BVMs take-up space ... upwards of 50% of a med bag’s compartment.

So, why take-up so much space ... for only 1% of your calls?

The lightweight, fold-in, compact design of the Pocket BVM makes it the most versatile BVM on the market!

CASE SCENARIO

Your EMS crew is responding to the report of a “party down” at the bottom of an embankment of a local trail.

Automatically, you dual-respond with both ambulance transport and off-road rescue resources.

Equipped with general trauma & splinting supplies, equipment for patient movement, and a lightweight first response bag, you trek toward your patient.

He’s significantly injured ... has shallow respirations ... and is determined to be unstable.

You begin with the ABCs ... seeking your compact Pocket BVM. Because of its compact size, you’re able to carry it in any bag or compartment space. Combined with oxygen tubing that is ready to be connected, or even an oropharyngeal airway, you’re easily able to perform basic airway management right on scene ... without having to run back to your ambulance for additional airway supplies.

SOLUTION

Could you have carried other equipment ... ran back to your ambulance for additional supplies?

Sure.

But, that’s not the point ... that’s not being prepared to respond to different situations. That’s not being versatile and ready to respond to the different challenges within your geography.

Those options are work-arounds ... alternatives ... not solutions.

Changing what you carry ... adapting to the needs and demands of your calls ... that’s seeking a solution.

Incorporating the Micro BVM line of resuscitation products into your response cache can provide a Big impact ... in a micro way. It’s all about preparedness ... and in our line of work, that means carrying the right tools for the job ... and space is certainly a “hot commodity” that you need to account for! EMSDIRECTOR

KEY ADVANTAGES:

Most compact BVM on the market
Saves 75% in space
Proven in military & civilian emergencies
Robust package that withstands tough conditions
Top quality materials for top performance
Reduced dead space with BVM design
Able to withstand both high & low temperature storage environments
Leadership Recipe

Finding Great People

DAVE JOHNSTON
BBA, EMT-P

What makes an EMS agency - or any other organization - great?

The answer to that question is easy ... great people. It’s nice to have top-notch gear, brand new ambulances, cutting-edge protocols, and education opportunities that boggle the mind ... but if you don’t have great people, the organization is never going to flourish.

Unfortunately, it’s the community and the patients we serve who are really the ones who suffer when an organization stagnates. So, then the big question out there is, “how do we find great people?”

All agencies are searching for the right person to bring into their organization – to help it grow and to help other good people grow. The potential for an organization to do great things for their community is huge when you have the right people and they are passionate about their job.

In my own EMS agency, we have tried many different methods to find the right person that would be successfully in our organization. We focused on finding great EMS providers by looking at how they performed clinically in their internship and in contrived patient scenarios. This also carried over into how we were evaluating promotional candidates. We were looking for great paramedics and EMTs to fill those roles.

HIRE CHARACTER, TRAIN SKILL

In our search to find great EMTs and paramedics, sometimes we get it right ... while others, we get it wrong.

About six years ago, my organization began taking a new approach toward building a culture of leadership in our own hiring, operational, and management practices. Through this new focus, we began to notice greater success in finding the right people to fill our vacant positions.

In prior years, our organizational culture was such that if they were not a good fit, then they typically exited our system in a timely fashion. Since adopting a new approach, moreover, this shift in culture moved us from looking for ways to identify great providers, toward looking for great character traits.

This change and it was best summarized by Peter Drucker: "If you don’t have the right people, you can’t have the right culture.”

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Subscribe to see more!
The next crucial step is to assess the performance and evaluations by current supervisors to determine if the individual has demonstrated a mindset of always working towards success. In individuals that have a history of needing very little supervision to have tasks completed, it is evident that they have a self-motivated mindset that leads to improvement. This trait can be assessed through a general interview, asking specific questions about interactions and asking what the person did to improve themselves in the aspects of professional development, education, and personal attributes. Additionally, assess what the individual has done to improve themselves in the aspects of professional development, education, and personal attributes. The important aspect of assessing this trait is in how they have demonstrated self-motivated improvement. What did they actually do, and what did they plan on doing to do that pursuit. I hope you find some savory examples of wonderful people that can make our profession better. In leadership, as in cooking the best dishes, they are always adjusted for your local conditions. The kitchen is open, so get busy making a new Chief of Emergency Medical Solutions, LLC

DAVE JOHNSTON

is the new Chief of

EMS

DIRECTOR

EMS

P,

DIRECTOR™

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DEVELOPING A QUALITY CONCEPT

TIM NOWAK
AAS, BS, NRP, CCEMT-P, SPO, MPO, CADS
Editor-in-Chief

Develop your own **Quality Concept** when it comes to quality assurance. What does that mean?

Determine what you feel is an important part of your equation to equal success in your performance as an EMS professional.

If you’re uncertain of what to look for, or what’s important to you (off the top of your head), then feel free to learn from some of my insights & thoughts (and lessons-learned!).

**Quality Concept:**

Quality Education  
Quality Training  
Quality Assurance  
Lead to Quality Performance and Care

Looking at each component of this concept & theory individually can provide you with a bit more insight as to what I’m referring to when I strive to promote quality within my teaching, within my performance, and within my actions as an EMS professional.

**QUALITY EDUCATION**

This is knowledge supplied by delivering attending class material. For me, this encompasses a variety of different things, but the key component is delivering knowledge into the equation of providing quality care.

**QUALITY TRAINING**

Knowledge supplied vs. knowledge applied... utilizing your supplied knowledge and putting it to work - or applying it - is what can make you a great provider, instructor, manager, leader, and just an all-around good person.

**QUALITY ASSURANCE**

QA is more than just chart reviews/audits, skills performance evaluations, and competency exams... it’s encouragement, praise, constructive criticism, conflict management, and challenging one’s abilities to promote success all in one.

Promoting Quality Performance and Care is what we do in EMS... every call, every day, every provider to our patients — regardless of the number of times we’ve been to their facility - "frequent flyer" events.

You never know where the day may lead.  
Take the classroom with you.

**Subscribe to see more!**
Being an EMS company officer affords individuals many perks ... advantages. It also places upon them many responsibilities.

Being a partner, having a command presence, being involved in oversight, seen as a resource, even a mentor, and also an advocate.

Being an advocate brings with it many of its own challenges ... and opportunities.

In many respects, being an EMS company officer is like being a “middle-man.” Whether your title is “senior,” is administrative like “supervisor,” or rank-driven like “lieutenant” or even “battalion chief,” your responsibility as an advocate is to field in-coming complaints & requests, make on-the-spot decisions, and act as a person of influence on each call.

You’re a leader ... leading from the middle-outward, rather than from the top-down, or bottom-up. You have the eyes and ears of both superiors and subordinates.

You’re Congress (politics aside)... a REPRESENTATIVE ... you have the ability to take what your constituents have to say and turn it into producible actions ... as well as take words from a higher authority and disseminate them downward.

You’re a key component of providing closed-loop communications. You gather information, report it to others, and share outcomes & results. You retain, report, and reply information. You’re an advocate for those both superior and subordinate. And conversely, you’re a part of the oversight process ... assuring that proper procedure & accountability is maintained.
Considering that your position sits right in the middle of where those who are working, needs fixing, or operating just fine... it is your role to fielding inquiries and communicating them back to administrative staff.

By no means does that mean that you have to be a yes man. You should be respected enough to express your clinical competence, and exemplified your ability to mentor others.

At the end of the day, management staff should know that you’re working as a REPRESENTATIVE to both superior and subordinate staff... all while respecting that you’re also a REPRESENTATIVE to yourself... an advocate for your own development, too. EMS DIRECTOR

You’ve got ideas... ambitions... and given this platform of both responsibility and authority, it is your right to have a higher-level of respect toward expressing them!

You’ve worked hard, lead by example, shown your clinical competence, and exemplified your ability to mentor others. Now, it’s your turn to get some of that in return. You should be able to have the closed-door discussions with administrative staff that subordinate field providers might not otherwise be granted.

You should be respected enough to express both your approval, and dissent, on given topics.

Let’s face it, being a company officer is a “natural” transition toward becoming a chief officer. Considering that, don’t forget to advocate and REPRESENT yourself along the way!
“Your social media page is out of control!”

Social media is here to stay. Facebook, Instagram, Twitter, LinkedIn, and Reddit are near-universal forums for employees of all ages ... and our new EMS professionals have literally grown up on social media. Certainly, there is a case to be made for social media conduct policies - particularly with regard for patient information, disclosures of business practices, and personnel grievances - but those policies often are either inadequate or vague ... and are often misused and misunderstood.

What is an employer to do when the conduct in question does not involve the workplace, does not target the workplace, or is a legitimate regard for patient information? For a threat, through or within “lead” opera appro. This I Despi by no you to any do any fi man; what First, inclu issues speak.

For discussion ... as is the degree of scrutiny that leadership places on employees.

Discussion, both internal and external, affects the reputation of the employer and communication cannot be effectively controlled in a time when personal messages and anonymous threads exist. Organizational reputations are hard things to build ... and in a field like EMS, which relies upon frequent infusions of new employees as well as public goodwill, they need to be protected. Becoming the employer known for draconian social media policies isn’t exactly a winning strategy for recruiting Gen Z.

Second, social media communication is generally held to the same standards as other workplace communication. This means that communications that do not involve subjects explicitly confidential by law and/or policy are not necessarily matters for discipline. This protection also means that discussions of wages, hours and working conditions are protected. That’s right – employees are specifically protected in discussion of wages, hours, working conditions, and other relevant workplace issues ... which stretches a long way!
The treatment of employees for speaking their minds is certainly fair game for discussion as is the degree of scrutiny that leadership places on employees.

It is important for managers to remember that what is considered ‘protected’ conduct under the National Labor Relations Act is broadly defined to include any conduct that is undertaken to engage in or support protected activity even when the conduct is not protected activity itself. What is protected conduct? A review of the NLRB vs. EchoStar case from 2013 illustrates a key point.

EchoStar’s social media policy had a clause that stipulated that no one should be intentionally disrespectful or insulting. That clause was challenged by a supervisor and employee in a hospital setting. The employee’s comments included yelling at today is actually protected.

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The pulse of the EMS industry can be easily palpated by a quick scroll of any social media page. The argument over degree vs. non-degree EMS professionals, wage discrepancies, and an overall lack of opportunities are all topics that flood our feeds. Solutions, such as “my company should pay me more,” or “I should earn what I’m worth,” are all floating around the internet and falling on deaf ears.

Remember your first day of EMT school? I recall it quite fondly, as I was young, impressionable, and naïve. During the first few weeks of the class, the idea of patient advocacy was driven home in a big way. Concepts such as, “first, do no harm” and “it’s about people” are all phrases that I remember being repeated over and over again.

We discussed the well-being of the EMT, covered our role as a mandated reporter, and solidified our position as our patient’s number one advocate. And through all of the great lessons in that initial EMT class, we failed to spend a single moment discussing the well-being of our profession. Our educational institutions were so busy cranking out certified providers, that we neglected longevity.

It may seem odd, but we are our greatest roadblock to the progression of our industry. Too many keyboard warriors are fighting battles as individuals instead of organizing with like-minded providers. Virtually every state has an EMS association, and we have several options at the national level for organizations that fight for the benefit of us. However, these organizations fall short of succeeding because we are fighting the wrong battles... and doing so in too few a number.
If we could turn the passion that I see on social media into organized advocacy efforts, I believe we could see change. If we could stop looking upon our agencies as the problem and divert our attention to the real issues, we could see change. EMS has become a stepping stone for a higher paying job. Do we dare to place that at the top of our list of concerns or is it a silent mission statement? If we are no longer forced to work multiple jobs, and when we receive ample rest between shifts, I believe that we will see decreases in the effects of PTSD. We will see decreases in ambulance accidents, back injuries, and other negative consequences often associated with our industry. We can ve our job s.

If there was a time to advocate, that time is now. It is my belief that we can come together as a singular voice, advocating for our cause. I further believe that this begins with a change to the reimbursement structure. When we receive reimbursement commensurate of the services we are providing, we can then be compensated at rates consistent with the work that we are doing.

The answer is simple ... and it begins with us.

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LDRSHIP, ARMY STYLE

In the military, your obligation may include maintaining combat operational readiness. Your duty in the department that you work for, may be to ensure that the trucks are staffed, and trucks are rolling.

You also need to remember your duty to those that work for you. They come in and do the job that they are supposed to, so you need to ensure that you maintain your duty to them ... ensuring that they get the things that are needed and the benefits that are promised.

RESPECT

Respect is a unique attribute that is very fragile. A quote online said that it takes “20 years to build respect, but 5 minutes to destroy it.” This is very true. The first part of respect is to treat others the way that you want to be treated. When you start with doing this, you will see the levels of respect grow.

Another aspect of respect is positional. You may have lost respect for an individual on a personal level, but when working in the

LOYALTY

As a manager, your loyalty: understand department including the local, the state, and the Federal Government. There is the for you, the understand

DUTY

In the Army you must fulfill your the same as difference in the set of obliga
How does EMS advocacy need to change moving forward?

What should we advocate for?

What should we stop advocating for?

I think we need to reorient EMS advocacy away from clinical changes and toward operational changes. It is really, really hard to attract people in a competitive labor market with paramilitary organizational models, poor leadership, and long hours ... for low wages.

ROBERT | Texas

Ambulance fee schedules will need to be adjusted to increase compensation, and allow organizations to operate at efficient staffing/resource levels. No matter how good our intent, the financial component must be addressed to truly implement the change we seek in the ambulance industry.

RYAN | South Carolina

We have enough physicians advocating for clinical improvement ... we need EMS folks advocating for operational, educational, and financial improvement.

How about requiring candidates for supervisor positions to hold the Supervising Paramedic Officer (SPO) credential, candidates for manager to hold the Managing Paramedic Officer (MPO) credential, and candidates for the director/chief to hold the Fellow of the American College of Paramedic Executives (FACPE) credential?

SKIP | North Carolina

Leadership training should be mandatory prior to getting that position. Now, most every supervisor or manager is being promoted from within and it becomes the “Peter” principle. They have no idea how to lead. People leave management; not their company.

JON | Texas

It’s time that we advocate for EMS as its own industry ... its own profession ... not just a tag-along to another service model.

This means that fire departments, hospitals, municipalities, and other entities need to focus their efforts (and funding) toward “EMS development” ... not just “EMS as a part of ___.”

TIM | Colorado

I don’t want to become a nurse ... I want to remain a paramedic! Let’s promote commensurate education and associated pay ... representation with associated support ... respect with associated funding.

HOLLY | Florida

Degrees ... sure ... but appropriate degrees, with an appropriate curriculum, appropriate timeframes, and appropriate costs.

Spending $30k on an in-person BS degree sounds like exactly that ... “BS.”

Spending only $10k on a more appropriate associate’s degree ... with clinical time, classroom time, and a focus on building functional providers ... I’m all for that!

CHUCK | District of Columbia

Advocacy needs to be emphasized locally, just as much as it needs to be emphasized nationally. Yes, CMS might control reimbursements on the larger scale, but communities control funding up-front and immediately. If they don’t believe that we (EMS) are an “essential service,” then they sure as hell won’t be willing to pay for it! If you think that recruitment & retention are issues ... try reimbursement & funding as its starting point!

MICHAEL | Wisconsin

We should stop advocating for “bridge” programs to nursing or other fields. It always seemed to be counter-productive to offer scholarships to medics and EMTs to go to nursing school, but not offer EMT’s scholarships to obtain paramedic training ... or paramedics scholarships to attend leadership conferences, or advancing their education within the field.

We should probably stop treating EMS as a “business” run by business majors, and start presenting it as either a public safety organization, or as a public health entity.

Or, admit we’re a business ... quit trying to beg for tax increases and public monies, and start managing the process to produce the product expected.

Also, we should advocate for national reciprocity and portable licensure from state-to-state, allowing for a more-developed career ladder.

JOHN | Mississippi

Aside from the “usual” debates over reimbursement, recruitment, retention, degrees, and “what” to call us ... how about a renewed sense of safety?

At the expense of safety, we’re still willing to buy (and build) ambulances with bench seats ... paint them red ... make them massive. How about shifting our focus toward actually embracing safety, rather than using it as a punch line?

WILLIAM | South Dakota

EMS should be a profession ... a career ... in itself; not just a supplement or a stepping stone. If we can’t accomplish this, then all of our other arguments, debates, or concerns may not really matter.

JAMES | New Hampshire
Does Your EMS Agency Have A “Weight Problem?”

Rest easy. This article is not going to discuss the myriad of issues regarding physical fitness and EMS. Nope. Actually, it’s about something that—if not addressed—could have greater consequences than one or more out-of-shape paramedics. I’m talking about vehicle operating weights here.

In several recent visits to EMS agencies, I’ve asked leadership about vehicle weights. This seems to be one of those questions that nobody asks about (if they have a concern about it at all), but can have serious consequences for the agency. I’m talking about vehicle weights in general—and specifically about vehicles operating in emergency services—which are in excess of the manufacturer’s Gross Vehicle Weight Rating (GVWR).

The GVWR is the manufacturer’s specification for the maximum weight at which the vehicle can safely be operated. It is made up of two components: curb weight and payload. The vehicle’s curb weight is the weight of the vehicle and anything that is permanently bolted to it. That includes things like siren speakers and suction mounts, but not suction machines or cardiac monitors. It includes standard equipment and all necessary operating consumables such as motor oil, transmission oil, coolant, air conditioning refrigerant, a full tank of fuel, while not loaded with either passengers or cargo. Payload for an ambulance includes biomedical equipment (monitors, pumps, suction machines, etc.), medical supplies and drugs, stretchers, oxygen cylinders, and anything else normally carried on the vehicle... as well as the humans that will be in the vehicle when it moves.

Why does this matter? In several cases, ambulances have been found to be suffering from “cracked frames,” which could be the result of carrying excess weight; significant interactions with potholes, and other types of excess wear and tear. Others “go through brakes quickly” while others ride more roughly than expected.

Operating a vehicle above the GVWR can have a variety of other consequences, including:

- Excess wear and tear on brakes and transmission
- Loss of steering control (due to the fact that the greater weight of the vehicle is in the rear, resulting in a shifting of traction from the front to the rear tires)
- Too much stress on the various mechanical components of the truck (leading to failure or breakdown of the components—including the vehicle frame)
- Tire blowout (due to too much weight)
- Increased speed when traveling downhill
- Decreased speed when traveling uphill
- Longer stopping distances (increasing the risk of causing rear-end collisions)

Many EMS agencies work hard to minimize vehicle costs, including (in some cases) buying vehicles without sufficient weight-bearing capacity to safely do their jobs. This may present a false economy, providing an up-front savings while increasing the cost of parts and repairs over the cost of the vehicle.

The topic of weight is addressed in the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Standard 2.0 (GVS 2.0), section C.6.2. This section provides that “the required minimum payload (patients, passengers, and cargo/equipment) per vehicle, with optional permanently mounted equipment, shall be 1,300 lbs.” (1)

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This standard, which should be familiar to anyone involved with purchasing or maintaining ambulances, includes a worksheet with a calculation methodology. Interestingly, the worksheet assumes that each seated position (including crew and patient) weighs in at 171 pounds (C.6.2.2). Section C.6.3 provides that “the combination of the vehicle’s curb weight and total usable payload weight shall not exceed the ambulance GVWR.”

In discussing this issue with others, I’ve noticed a disturbing trend—an effort to seek out ways to “game” the GVWR question. This is not a good idea. A service might save a few dollars on purchase costs, but incur higher operating and maintenance costs over the life of the vehicle, or (worst case) a catastrophic event that might cost lives or incur significant financial liability.

It’s better to plan for a vehicle that can carry everything that you currently carry, including two of your largest personnel, and a patient of equal or larger size. Don’t forget the additional people who might ride along (students, observers, or other agency personnel helping on the way to a hospital). If you carry rescue tools, spare devices or equipment, employees’ lunch coolers or PPE (including body armor and helmets), include them too. Snow chains or a bag of ice melt? Make an allowance for things that you might decide to add during the life of the vehicle—is your agency looking at mechanical chest compression devices, ultrasound units, or portable ventilators? Add this all up and buy a vehicle whose GVWR still allows for some extra weight to be added.

Typical ambulance chassis GVWRs are:

**FORD**
- E/F 350 chassis: 14,000 lbs.
- E/F 450 chassis: 16,500 lbs.
- E/F 550 or 5500 chassis: 19,500 lbs.

**CHEVROLET**
- 3500 chassis: 12,300-13,200 lbs.
- 4500 chassis: 14,200-16,500 lbs.
- 5500 chassis: 19,500-23,500 lbs.

You can see that a single step up in chassis selection can gain the user up to 2,500 additional pounds of GVWR, from which must be subtracted the increased weight of the chassis itself to determine the gain in payload. Or, ask several vendors to provide you the “payload worksheet” as shown in the National Truck Equipment Association (NTEA) UltraMod spreadsheet (available at www.ntea.com), which is referenced in the CAAS standards.

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(1) Commission on Accreditation of Ambulance Services (CAAS) — www.caas.org
(4) NTEA UltraMod spreadsheet — www.ntea.com
John T. Riggs

As I sit writing, Tropical Storm Barry is sitting just off the coast of Louisiana... dumping inches of rain into the marshes of the state. Due to heavy rains in the Midwest and flooding along the Mississippi River valley, this means a serious situation is developing for these areas. Flash flooding is expected in the near future and this means that the area may well be flooded for hours or days of it.

Looking at this problem... what do you see for this area?

Longer response times, crew reductions, development of new/emerging issues, and concerns are now on the minds of emergency services teams as they confront future challenges, and the long-term business... Emergency services (including continue operations... 24/7). We can “shut down” their rigs and facilities from flooding... but where do the operations require an up-ramp and how do we plan for the return of the rig?

As a result, here are some suggestions to the next emergency event:

Help employees create Emergency readiness... of the stress of working during long-term events by ensuring they have what they need that can be easily accessed. Have accessible food and water. Write plans for bringing in supplies, a... especially with a reasonable lead time for distribution to the area.

Be prepared to say “no.” Crews who provide services. Monitor crews and buildings for crews that have worked too long... or who have run multiple calls back to the same event. MREs may not be the best delicacy, but they are available and a reasonable lead time... to provide food and water for your apparatus.

Make connections BEFORE the event. Emergency operations require an up-ramp and down... and avoid unexpected events. Have accessible food and water. As these are meant for direct leadership roles. The primary goal... of the area.

John T. Riggs
BS, NRP, DCMEI
FINANCIAL FORECASTING: 3 CONSIDERATIONS

TIM NOWAK
AAS, BS, NRP, CCEMT-P, SPO, MPO, CADS
Editor-in-Chief

2019 is shaping-up to be one heck of a year! From the discussions surrounding cost reporting, to the introduction of ET3, and even the debate surrounding degrees in EMS, 2019 is certainly making a 1966-like impact on our industry (referencing the infamous “white paper”).

As a result, your “F” role in the organization, certainly in a state of excitement. Forecasting for the future is a key administrator’s mind ... include scenario analysis, which is a form of SWOT analysis, in your strategic plan. As such, here’s three considerations to not only keep in mind, but to communicate with your stakeholders and employees now may alleviate the anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your organizational structure is designed to handle anticipated hiring needs, or freezes? Being up to PAR will look at your

THE PROBLEMS WITH PHYSICAL RESTRAINT IN EMS

DAVID DUFÉK
Flight Paramedic

There is a common understanding among healthcare providers that restraining uncooperative patients is difficult ... and one of the more dangerous interventions we perform.

Throughout my career as a paramedic, I have witnessed injuries to my body. Body motion, exposures, or injuries are caused by the restraint process. Some of these injuries are caused by restrained patients. Whenever on restraint training in the medical setting or during restraint training, the same stress is caused by restrained patients. Extended training and updates to training, equipment, and after employment to minimize the risk of injury to EMS providers when treating uncooperative patients.


Subscribe to see more!
Testimonials

“XD-CUFF deploys much faster than traditional restraint products. This speed allows us to treat and transport the uncooperative patient faster than before.”

Lt. Jenny Nist  
St. Johns County Fire Rescue

“The XD Cuffs being already secured to the stretcher in a preferred spot is a big bonus. The quick synch, feature is by far the biggest time saver. I feel safer and more confident using the XD Cuffs over others.”

Justin Thomas  
Firefighter/Paramedic (FTO)  
Flagler County Fire Rescue

“XD-Cuff is the first limb restraint product that I’ve seen work in EMS”

Mark Davis  
Director  
Desoto County EMS

To learn more on how we can help improve risk management and patient care for your EMS or fire-rescue department, contact us directly for details or a free trial.

E. David@xdcuff.com  C. (361) 275-8261  W. www.xdcuff.com Training videos on YouTube® & TargetSolutions®
DATA INTEROPERABILITY
(AND ITS ET3 RELATIONSHIP)

CHAD ALBERT

In the last issue of EMS Director, I talked about digital transformation and some ways that digital transformation can impact EMS operations. I wanted to follow through on that discussion and talk about data interoperability.

Data interoperability is a broad term that covers the ability of disparate systems to consume and use data.

In healthcare, that generally means using established standards, terminologies, and ontologies that provide meaning, rules, and structure to data to ensure that the meaning of the data is consistent and able to be understood.

Data interoperability is critical to digital transformation. It provides the framework to send & receive data across applications and business entities. In my humble opinion, data interoperability will provide the community with the ability to consume and use data.

In healthcare, data interoperability is the key to unlocking the value of healthcare systems. Data interoperability is the key to unlocking the value of healthcare systems. Data interoperability is the key to unlocking the value of healthcare systems. Data interoperability is the key to unlocking the value of healthcare systems. Data interoperability is the key to unlocking the value of healthcare systems. Data interoperability is the key to unlocking the value of healthcare systems.

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There are a variety of reasons, but I think there are two that cause the most issues. The first is an issue generally known as “vendor lock-in,” and the second is that data has tremendous value ... and the owners of that data often either don’t want to share, or don’t want to make it easy for you to switch providers.

Vendor lock-in is a scenario where you are “locked” in to a vendor’s software, and it is difficult or very costly to take your data to a different software vendor. Anyone that’s switched ePCR vendors knows it can be a significant headache. Some vendors love this ... it keeps their revenue coming in!

Why is data interoperability important to EMS?

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A Case Study for EMS Advocacy

SEAN CAFFREY
MBA, FACPE, NRP

If you inhabit the EMS social media space, you will frequently find folks lamenting that the federal government should be doing X and that state EMS rules require Y.

In almost all cases these comments are a plea for change.

Interestingly, however, ongoing engagement in advocacy efforts by EMS leaders is uncommon. Interestingly, many EMS leaders complain that they don’t join state and national organizations because they don’t see the value. all while simultaneously complaining that EMS needs a “seat at the table.”

So, how do we address this gap as leaders?

The first step is understanding what advocacy is. In broad terms, advocacy is seeking to affect some change in society. That may include appealing to individuals to change their behavior, asking a governmental agency to change its rules, or asking a legislative body to change the law.

All organizations are allowed to advocate. In particular, any EMS organization is free to interact with government agencies that develop and/or enforce regulations or to engage the public on issues directly. Restrictions come into play when governmental or non-profit EMS services engage in lobbying—which has a more specific definition. Lobbying is the act of influencing legislation in a state legislature or Congress. Specific organizational policies or tax law requirements may restrict the amount or types of lobbying that some organizations may engage in. In general, however, restrictions only apply to certain activities or expenditures. Participation in lobbying through state or national organizations, however, can be an effective alternative to lobbying on an individual or organizational level.

As a case study, the Emergency Medical Services Association of Colorado (EMSAC) is a non-profit organization formed in 1973 that holds 501(c)3 status granted by the IRS. As a state-level EMS organization formed in the early days of modern EMS, the association serves as both the state ambulance association and the statewide professional association for EMTs and paramedics. The association seeks to actively recruit members of all system types - including hospital-based, private, third service, and fire-based services.

Both individual and organizational memberships are available with the vast majority of membership being signed up through organizations. In recent years, a push has been underway to bring our non-profit EMS and Trauma Regions onboard as members.

In addition to membership revenue, the association runs an annual conference that attracts 700+ attendees in a state with 18,000 providers. All of these demographics are important to understand because it allows the state association the opportunity to speak effectively on behalf of many EMS interests in the state, all while having the benefit of resources to apply toward advocacy activities.

Around the turn of the 21st Century, EMSAC created an advocacy committee... by accident. The CEO of a large private ambulance service doing business in the state was on the association’s board of directors and allowed the association to utilize their paid lobbyist at the state capitol to advocate for EMS-related issues. This arrangement made the private company’s lobbyist a more effective voice of the industry—all while giving the association a no-cost entry into the world of lobbying.

The newly formed advocacy committee was needed to help direct those efforts. After using this approach for a number of years, the association made a fateful and financially risky decision in 2006 to hire the lobbyist directly for approximately $30,000 annually. In recent years EMSAC has also contracted with a part-time communications director to regularly update and engage our members in matters of legislative and regulatory interest.

As a case study, the Emergency Medical Services Association of Colorado (EMSAC) is a non-profit organization formed in 1973 that holds 501(c)3 status granted by the IRS.

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Having had an advocacy committee and lobbyist in place for over a decade now, EMSAC has experienced many successes in passing new EMS-related legislation, has been routinely invited to rule-making processes convened by our state EMS agency, and has been able to successfully oppose problematic legislation and/or rule making. More importantly, however, we have been able to build ongoing relationships with other advocacy organizations, elected legislators, and regulatory agencies.

In terms of legislation, one of EMSAC’s earliest successes was doubling the per-vehicle fee used to fund EMS at the state level from $1 to $2 per vehicle. This legislation created a competitive grant program that funds $5-6 million in EMS and trauma related vehicles, equipment, and programs each year. As a result, EMS services in Colorado are largely well-equipped with reliable vehicles regardless of their size or staffing model. Other legislative accomplishments have included:

- Increases to Medicaid payments for ambulance services
- Creation of a public provider Medicaid reimbursement
- Co.
- Cr
- para
- Em
- requ
- ambh
- Inc
- prov
- Au
- shar
- Cn
- assis
- De
- pred
- rend
- Cr
- advi
- mom
- Ex
- depa
- regu
- Adv
- to pr
- clin
- Sta
- para
- that
- EMS
- Stars of Life
- President of the EMS Association of Colorado and the President Elect of the National EMS Management Association.

Most of these laws have passed with limited opposition in both democratic- and republican-controlled legislatures.

As a state association, most of EMSAC’s activities have been at the state level. EMSAC leadership believes this is the best place to focus association efforts as a majority of the issues and regulations concerning EMS are state-level issues. While the association does encourage participation in federal activities, such as EMS Day on the Hill and the Stars of Life award program, lobbying on federal issues is mostly left to national associations such as the American Ambulance Association and the National Association of EMTs ... among others.

None of this state-level success would have been possible without an advocacy committee willing to engage on the details of public policy and travel to testify in front of legislative committees, often on short notice. Additionally, the employment of a professional lobbyist, who - in this case - case shares his representation of EMS with other clients, has been a critical factor to EMSAC understanding the dynamics of evolving legislation, the political landscape, and the various organizations who support or oppose bills under consideration.

We have also found it critical to keep lines of communication open with leaders of our various organizations who support or oppose bills under consideration. The need for regular updates on activity levels, both the state and national level. Your respective EMS or ambulance associations at the state and national level. Your membership dues and your engagement are key factors to influencing public policy. Willingness to volunteer, especially when it comes to studying up on policy proposals, travelling to provide testimony, and participating with state agency committees and task forces is also an important factor in success.

Being willing to talk, especially with organizations and officials that disagree with you, is important to building understanding and trust over the long term. While some years have important legislative gains, others are measured by stopping unwanted legislation. Some years, nonetheless, are simply uneventful. Regardless of the activity level, the importance of having a regular presence at the legislature in terms of a professional lobbyist cannot be understated. With that level presence, you can make change happen. Without it, change will happen to you.

There is no better time than today to step up and start shaping the future of our profession and our industry. Of course, if that sounds like too much work, you can always gripe about the status quo on social media and lament that you don’t get anything for your association membership dues.

SEAN CAFFREY, MBA, FACPE, NRP, is the Vice President of the EMS Association of Colorado and the President of the National EMS Management Association.

EMSAC has experienced many successes in passing new EMS-related legislation, but there is no better time than today to step up and start shaping the future of our profession and our industry.
How Bold
Should You Be
in an
EMS Interview?

On my way to work this morning (with a drive that lasts about an hour) I often listen to audio books as a way to clear my head and use my time the best way possible.

Today, while listening to “Leadership: In Turbulent Times,” by Doris Kearns Goodwin, one story in particular spoke directly to the question of boldness during the interview process. In short, this story spoke of the moments immediately prior to Abraham Lincoln’s signing of the Emancipation Proclamation.

Witness accounts state that President Lincoln proclaims any sign of tremor in his handwriting will forever be interpreted as hesitation in signing the document. Then, President Lincoln signs the Emancipation Proclamation with a “clear, bold, and firm” signature. Abraham Lincoln had the forethought of the gravity of the document that he was about to sign, that he did so ... boldly.

Do you remember your last interview for an EMS job? Did you prepare for the interview? Were you asked any questions about your work ethic and skill-set ... or were you just hired on the spot because “we have a lot of openings”?

As EMS progresses as a profession, so should the process we call the interview. EMS is a profession where most paramedics and EMTs are known throughout their respective region. In most cases, you already know the person hiring you and they know you. But, what happens when it’s your first interview for an EMS job ... or you are applying for a job outside of your geographical comfort zone? It is easy to believe the preconceived notion that you don’t need to take an interview in EMS seriously because EMS is always hiring. But, don’t we want to change that?

BE BOLD

Any interview, no matter where you are, is an important step in the process to define what sets you apart from everyone else and what you have done to make sure you were the best candidate. Here is the time to be bold in your interview. Use clear, bold, and firm handwriting. Set the standard from the very beginning. Now, for the formalities. Dress like you want the job. Taking the time to dress nicely is an interesting strategy that doesn’t go unnoticed. If you are willing to dress like you’re serious for the interview, it shows you are serious about working there.

Arrive early. No boss or hiring director likes it when you’re late. If you have to be late, take the time to call and see if you need to reschedule. The person interviewing you will appreciate it.

There is a catch though ... if you apply online, most of those templates don’t accurately describe your work and experience. Be prepared with a robust resume or CV that is more important than your time during the interview.

Put down the phone. Arrive early. A boss or hiring director doesn’t need to see any phone calls or emails going on while you are waiting. The person interviewing you will notice. Take the time to call and see if you need to reschedule. The person interviewing you will appreciate it.

Now, to all of the EMS directors, administrators, and chiefs ... don’t we want to change that? Collectively, we want the profession to move forward ... and this is one way to make that happen!

Subscribe to see more!
It is okay to be bold enough to not hire someone ... so be bold enough to conduct a serious interview! Put down the phone and put the computer to sleep. Are you tired of hiring mediocre employees? Stop hiring every person that walks through your door! Pretty bold concept, huh?

If your agency is known for hiring anyone that applies because you’ve got shifts to cover, then you’ll get just “anyone” applying for your available spots. Be bold enough to be selective in your hiring process ... and be bold enough to not hire everyone!

Take a little bit of time to discuss the accomplishments of the organization to your prospective employee. Don’t be afraid to put out there the great things you have done and give an oversight of where you want the organization to go. Give feedback and answer questions factually. Give your prospective employee an idea of what’s ahead if you decide to offer them a position, and what their expectations are. There is nothing worse than being in a situation where your new hire has discovered that you aren’t “the one” for them. The next 30 days are trying to find a new job and working on an exit strategy from yours.

Another important aspect for the person responsible for hiring is to not forget what got them into that position to start with. What kind of impression are you giving to prospective employees? Is your office a mess? Did you show up late? These are all things that can turn off the superstar employees you are looking for. Turnover is one of the biggest expenses for an EMS agency ... so it benefits everyone to give a right first impression in every aspect of how you manage your agency. Be bold enough to set the standard from the very beginning.

So, to answer the question as to whether be bold or not ... **BE BOLD**.

Be bold in your interview regardless of the side of the desk you are sitting on. Take your time to practice answers to the questions that you are going to be asked; drop clichés and be prepared with a concise and educated response. As an interviewer, take the time to review some HR guidelines to outline the things you can and cannot be asked. You sell yourself short if you’re not willing to be bold. Our profession needs bold employees and bold administrators to take EMS to the next level. Are you bold enough to be a part of it?

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**THE NEW MINICOURSE**

Sign up for our @911Leadership newsletter, and get access to our new miniCourse. A cutting edge tool on the Three Little-Known Communication Strategies Guaranteed to Breathe Life into Your Organization!

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Feedback from a recent participant:

“Listening to people is contagious! Actually hearing and processing what they had to say is so vital to my success. Also, not focusing on what employees are doing wrong...but focus on what they do right and what they can contribute to the organization.”

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**Subscribe to see more!**
Lately, the media has been filled with reports of violent attacks on paramedics. Members of our nation’s paramedic services have been stabbed, shot, punched, kicked, spat upon, and battered in a variety of other ways. Verbal assaults are too frequent to mention, but death threats and threats against family are also common.

All too often, within days, the media (particularly social media) is filled with comments from professional colleagues, unhappy with the response of law enforcement, the judiciary, and other authorities to these events. Protests and complaining, often just “preaching to the choir,” abound – but are unlikely to change the course of events for this or future cases.

An EMS organization that wishes to see a better outcome of its “assault on paramedics” cases needs to get out in front of these issues. It is not easy, and it is not something that individual street paramedics can do themselves.

It requires leadership and some hard work on the part of the chiefs and senior officers of the EMS organization; although in some circumstances, the EMS labor organization or professional association can also be helpful. As with most complex matters, good outcomes are dependent upon good, established relationships with the right people; and in some cases, having the right person on “speed dial” when the unpleasantness occurs.

KNOW WHAT THE RULES SAY TODAY!

What do your state laws say about assaults on paramedics, firefighters, police officers, or institution-based healthcare professionals? Does the law already provide for a higher degree or class of crime for assaults on your people, or is it an “ordinary” assault? If a battery or assault happens, what do you tell the investigator, magistrate, or judge that you want the perpetrator charged with? Is “communicating terroristic threats” a separate crime in your state? Beyond the statute, what do your law enforcement agencies do with these cases, and what do the judges know? Fortunately, these cases are infrequent enough so that an EMS case may be a “first time ever” for the people handling it.

WHAT WOULD YOU LIKE THE RULES TO SAY?

If you are unhappy with the status of the law in your state, the time to change it is now! Here, your union or professional association, or the EMS chiefs’ association, might be helpful. There is usually very little opposition to “enhanced status” bills in state legislatures. Your goal should be that battery or assault on a paramedic is classified as the same level crime as battery or assault on a law enforcement officer.

LEOs should never bully or discourage paramedics from pursuing charges, as sometimes happens. Paramedics typically go “above and beyond” for sick or injured law enforcement officers – we should be able to expect that same level of support from the LEOs who are supposed to follow up on our legal complaints. Many EMS agencies serve multiple jurisdictions, so this process may involve a number of meetings.

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LEGO LOGISTICS

DOUGLAS RICHARDSON
Paramedic, MS-PSM

In this example, I used a Captain, Chief, Battalion Chief, and Lieutenant. The Captain has unfettered access to the completed plan (the assembled Legos®), the Chief has unfettered access to the Captain and Battalion Chief, but cannot communicate with the Lieutenant. The Battalion Chief can speak to the Chief or Lieutenant, but not the Captain. The Lieutenant has all the parts and instructions, but cannot communicate with the Battalion Chief, but cannot communicate with the Chief without the Captain. The Lieutenant has the ability to communicate, but the Chief must communicate with the Lieutenant through the Captain, if the Captain sees fit.

This exercise teaches the importance of speaking clearly and following directions. It demonstrates the importance of feedback and affirming that a message has been received and understood. Another goal of the exercise is to build relationships ... to have members of the team develop a connection to other members of the team, and through training, develop trust.

Possibly the most important lesson is that this exercise teaches us to deal with hindrances ... how to deal with a situation when we can’t speak to the individual we want to and how to utilize other means of assuring that the message gets to all needed parties. EMS DIRECTOR

DOUGLAS RICHARDSON, Paramedic, MS-PSM, began his career in public safety as a paid-on-call firefighter with the Havana City Fire Department in Illinois. He attended EMT-Basic training in 1992 at Spoon River College where he is now an adjunct professor of prehospital medicine. Douglas is the Lead Instructor with Medics-CE, an online leader in delivering nationally accredited, online EMS continuing education. Douglas received his Bachelor’s degree in Public Safety Management from Franklin University, and his Master’s degree in Public Safety Administration through Lewis University. You can reach Douglas with any additional thoughts or comments at douglas.richardson@medic-ce.com.
I imagine that we’ve all been there ... sometimes learning more from the individuals throughout our careers that certainly weren’t mentors to us ... weren’t positive influences on our lives.

It was certainly an un-mentor relationship.

“Pat” was my un-mentor ... my first partner on the ambulance.

Any employee personality analysis would have proven that our working relationship should have never been. I was a new paramedic ... eager, excited, ambitious, and ready to learn more. He was hardly that ... complacent, burned-out, and not interested in teaching.

We clashed ... a lot.

Through that clash, moreover, I still learned a lot (just not in the positive way that I had hoped to).

Un-mentor relationships can sometimes teach us just as much as (and sometimes, more than) a healthy mentorship relationship can. The big difference - in the long haul - is that we can’t allow this pace to keep up.

Two, three, or even more continuous negatives don’t add-up to a positive. Positives add-up to a positive. Un-mentors - alone - shouldn’t drive your professional development. Un-mentors - alone - shouldn’t constitute your mentorship relationship with others.

As a manager, you have two options. Only one of them is successful.

Have you knowingly or unknowingly placed two individuals into a crew environment ... a relationship that was destined for failure ... a lack of mentorship ... a lack of learning? Were we both placed into a working relationship that was not successful because of ONE of us? Was our working relationship not successful because of the BOTH of us ... and not necessarily our individual shortcomings?

Is it possible that my other partner and I had no issues ... and have even been a combination of good matches? Or, was I the only one that was the common denominator. After all, I have proven that our working relationship was not a clear match with ... wondering if I was the one that brought out the bad in the other individual?

Is there a common denominator? How do people get paired in your organization? What methods do you (as the director, chief, or operations manager) decide who works with who? Is there an environment like this?

Have you knowingly set someone up in a environment like this? Or, was I the one that was so hard to get along with? Was I the one that brought out the bad in the other individual?

As a leader of an organization, we have often self-selected our team members or promoting new leaders within an organization. As a leader of an organization, we have often self-selected our team members or promoting new leaders within an organization. Whether it is the brand new employee or the current employee that is stepping into a new role like recently advancing from an EMT to a paramedic position. As a leader of an organization, we often self-selected our team members or promoting new leaders within an organization.

Have you ever set someone up for success or for failure? Do they have the brand new employee or the current employee that is stepping into a new role like recently advancing from an EMT to a paramedic position? Do they have the brand new employee or the current employee that is stepping into a new role like recently advancing from an EMT to a paramedic position?

Predictive Index optimizer ... someone who utilizes a personality analysis that is well worth the small investment to help build any organization ... not only for building teams with current staff, but also with on-boarding new team members or promoting new leaders within an organization.
An Un-mentor Relationship

TIM NOWAK
AAS, BS, NRP, CCEMT-P, SPO, MPO, CADS
Editor-in-Chief

Aside from some sort of predictive analysis, does your agency do anything to selectively, intentionally, partner individuals together ... to start a mentorship relationship? How about aligning an entire crew—or shift—together? Do you spin a roulette wheel ... or is there some actual "method to your madness?" What's the fix? Once you realize that either this working relationship (or your staffing experiment) isn't successful ... or is even toxic ... how do you step-in to remedy it? Or, proactively, what processes and mechanisms do you have in place—or available—to prevent this from happening in the first place?

Let's face it ... we all aren't going to get along 100% of the time. Disagreements—arguments—are normal. That's the nature of the beast. OR

Acute issues between employees - working relationships - aren't the "big" issue here ... but long-term, or even acute-on-chronic issues are.

Subscribe to see more!
As an organization of EMS leaders, NEMSMA believes strongly that our future leaders will be better prepared — and will likely be more successful — if they are drawn from a vibrant community of sophisticated, clinically adept, well-educated, and experienced professionals. The EMS profession in the United States is often made-up of fiercely independent providers fractured by state, training level, system type, and paid status. The work of building the profession of paramedicine has, therefore, become a primary goal of NEMSMA leadership. We know that the journey of professional advancement is never complete. We are working today to build an identity, claim a specialized body of knowledge, enact self-imposed ethical standards, and raise the bar to entry. The conversations we start today will hopefully become the status quo in 2030, 2040, and beyond.

The IAEMSC mission is to support, promote and advance the leadership of EMS response entities, and to advocate for the EMS profession. Our members are EMS Chief executives, senior leadership, supervisory staff, and aspiring leaders from rural communities to major metropolitan areas throughout the world. Our members serve 20 million citizens and respond to over 3 million EMS incidents annually. Membership includes career, volunteer, municipal, fire service, third service, hospital based, and private EMS sector representatives. Our programs support current EMS leaders while mentoring future EMS leaders. IAEMSC seeks to improve the way the world views EMS — motivating governmental and private entities to provide the much-needed funding and political support for EMS to remain effective and efficient.

Our Mission is to break-down the cultural barriers and foster the relationships between EMS, fire, law enforcement, telecommunicators, allied emergency responders, and the communities they serve. Our vision is for a stronger, more integrated public safety community capable of an effective joint response to all public safety incidents. The IPSA has EMS professionals on its board of directors, involved with committees (e.g. TEMS and RTF), and continually provides in-person and online training to the EMS profession. In addition, there are several EMS relevant research publications available, including the IPSA Journal.

The National EMS Museum is dedicated to memorializing the history of the emergency medical services while inspiring a future of EMS innovation. By supporting first responders throughout their careers with engaging programs and a rich collection of research resources, the National EMS Museum provides a unique network for first responders to connect with their history and their communities. Through public exhibitions and family-based programs, the National EMS Museum introduces aspects of emergency care and responding to communities across the world while supporting first responders and their families.
How is your association an advocate for professional development within EMS?

INTERNATIONAL POLICE MOUNTAIN BIKE ASSOCIATION
www.ipmba.org

IPMBA promotes the use of bikes for public safety, provides resources and networking opportunities, and offers the best, most complete training for public safety cyclists. This includes training programs for EMS Cyclists ranging, from operator to instructor, that enables them to respond swiftly and safely to medical calls in-progress in crowded and congested environments.

EMS ASSOCIATION OF COLORADO
www.emsac.org

As the only state organization dedicated solely to EMS, EMSAC serves the EMS system. The association speaks with a unified voice to assure the best care for victims of trauma and those suffering from medical emergencies. When organizations need the expertise and opinions of EMS professionals, they ask EMSAC. From position papers to legislation to public education, EMSAC is EMS in Colorado. Whether it be a legislative committee considering the operation of emergency vehicles, the development of the Colorado trauma system, or the Prehospital Care Program planning the next ten years’ evolution of Colorado EMS, EMSAC offers the critical perspective of those who daily provide, manage and plan emergency care.

AMBULANCE ASSOCIATION OF PENNSYLVANIA
www.aa-pa.org

The Ambulance Association of Pennsylvania (AAP) is the lead organization for the advancement of the needs of its members in the emergency and non-emergency ambulance and medical transportation industry. The AAP advocates the highest quality patient care through ethical and sound business practices, advancing the interests of its members in important legislative, regulatory, educational, and reimbursement issues. In accomplishing this goal, the AAP is dedicated to excellence in providing superior service to all facets of its membership and in developing positive relationships with other organizations associated with the medical transportation industry, through prompt communications and effective educational programs. In carrying out this mission, the AAP is committed to meeting the needs of its members in the volunteer, non-profit, and for-profit sector.
NEW (PAPER) PARTNERSHIP

BRIAN LACROIX
PRESIDENT

Some exciting news!

From time-to-time, the stars align enabling some pretty special things to occur. I am thrilled to “officially” announce that beginning with this issue - the National EMS Management Association has partnered with the EMSDIRECTOR to make this the “official publication” of our association.

EMSDIRECTOR is published by Emergency Medical Solutions, LLC, an independent EMS training & consulting company. Tim Nowak serves as the Editor-in-Chief. Starting now, NEMSMA and Emergency Medical Solutions have teamed-up to bring the paramedicine community a vibrant and enhanced print publication designed to support & inform leaders in our career field.

Members of NEMSMA will receive a complimentary subscription to EMSDIRECTOR mailed directly to your home or office on a quarterly basis. Independent subscriptions are available as well, but of course, we highly encourage anyone interested in the magazine to join NEMSMA and become part of the broader conversation. Additionally, sponsors and advertisers will have a new vehicle to connect directly with key decision makers in EMS across the country ... and beyond.

We are fortunate to be working with our talented Editor, Tim Nowak, whose background and experience – as well as his skills as a journalist – make him the perfect partner in bringing information to current & aspiring leaders across the country.

NEMSMA’s Immediate Past-President, Vince Robbins, serves as the Board liaison to the Publications Committee. Vince will be working with Tim to build an editorial board to help include our thinking about content and strategic direction. In addition, it is our interest to cultivate a platform to publish peer-reviewed research papers in the areas of paramedicine leadership and management. Precious little research is published in this area and we are hopeful that the EMSDIRECTOR will be a catalyst in growing the body of knowledge around what makes a good and successful public safety leader.

If any NEMSMA members have an interest in getting involved with the future of the EMSDIRECTOR, either via the editorial board or in providing content, please reach out to Tim and/or Vince. Their contact info can be found on our website (www.nemsma.org) or within this magazine.

At a time when newspapers and magazines everywhere are scaling back print publications and moving toward digital models, we believe there is a real & viable place for a printed magazine. Many of us still like to hold a printed piece in our hands and the EMSDIRECTOR fills a unique space - targeted at a medium-sized audience - with very distinctive interests & needs. The partnership between NEMSMA and Emergency Medical Solutions allows us the opportunity to offer this quarterly publication in an economical & sustainable way. We look forward to a long and successful relationship.

Enjoy! —NEMSMA

www.nemsma.org
About 700 people attended the Pinnacle conference this year, held in July in Orlando, Florida. It was the 14th Pinnacle EMS Leadership Forum – originated, organized, and conducted by Fitch and Associates. It was a week of education, exchange, inspiration, and especially networking. Pinnacle prides itself on providing a venue every year where colleagues in paramedicine can connect & collaborate.

The topics at Pinnacle ranged from hot topics facing the profession, presented annually by NEMSMA as Pinnacle Insights, to a review of trends developing in the industry with the 2019 EMS1/Fitch Trend Report. Sessions included areas of interest such as how the fire service model needs to evolve to keep pace with paramedicine in the U.S., to updates on the Center for Medicare and Medicaid Innovation’s (CMMI) ET3 pilot reimbursement model, as well as developments associated with CMS’s Ambulance Cost Collection requirements.

Some seminars addressed PTSD, depression, and suicide in EMS, what leaders can do to teach resiliency in their workforces, and innovative therapies like EMDR (Eye Movement Desensitization and Reprocessing) – which can assist first responders, including dispatchers, in dealing with the stress that leads to serious psychological distress.

Several NEMSMA Board members were among the faculty presenting at Pinnacle this year, including Past-President Vince Robbins, current President Brian LaCroix, Director-At-Large Hezedeen Smith, Secretary Brooke Burton, Treasurer Alisson Bloom, and Executive Director Pat Songer. NEMSMA also held its Officer Credentialing prep classes and exam during the conference. The association also conducted meetings for each of its various committees and its Annual Membership Meeting at Pinnacle.

The week was wholly worthwhile and provided the opportunity for NEMSMA to showcase the association and confab with other organizations representing different stakeholder groups within EMS. NEMSMA is proud to have become such an integral part of Pinnacle and connected so closely with its content.

Find additional information about the Pinnacle conference at: www.pinnacle-ems.com

Next Conference - July 27-31, 2020 - Phoenix, AZ
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of PARAMEDIC EXECUTIVES
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More Info: www.nemsma.org
(Check out the CREDENTIALING tab)

PARTNERING TO ADVOCATE

TIM NOWAK
AAS, BS, NRP, CCEMTP, SPO, MPO, CADS
Editor-in-Chief

First and foremost, I would like to welcome the entire NEMSMA membership to the EMSDIRECTOR magazine! Since its rebirth in 2018, this publication has grown leaps & bounds in terms of its recurrent columns, contributing authors, supporting advertisers, and now ... its membership.

From its beginning, this magazine’s focus has remained the same ... to promote Professional Development for EMS. As you’ll see (if you haven’t already been a subscriber), there’s very little focus on the clinical aspects of EMS - paramedicine - in this magazine. Rather, its focus is primarily directed toward YOU ... the director, chief, FTO, supervisor, and leader ... active, aspiring, and retired alike.

We’re all aware that our industry - regardless of the state (or even nation) that you operate in - has seen significant changes & growth over the past few decades. One of the challenges that we continually face in the industry revolves around both recruitment and retention ... particularly when it comes to our field providers.

Well, the administrators of our industry’s agencies are not immune from this! We still need to foster professional development within our ranks. We still need to advocate for progress ... share our stories ... mentor our future. That’s what this magazine is about ... being an ADVOCATE for our industry ... being an ADVOCATE for YOU!

I get great pride with seeing each quarterly issue of this magazine both come together and grow. What started as a 20-page magazine quickly grew into 40 ... and now to 60 ... and will likely see 80-pages in the near future. This is all because of the support that it’s gained from people like YOU, and from organizations like NEMSMA!

Now that we’re partners in this endeavor, I hope that you begin to see this publication as a representation of YOU ... just as much as I aspire for it to be just that.

Moving forward, I want to welcome you into this publication and express my interest in reading about your stories ... your vision. Please do not hesitate to contact me with your article ideas, suggestions for improvement, or general questions about this magazine (or even how to get more copies for your own stations!).

I’m incredibly proud of this partnership, and I’m looking forward to the relationship that we’ve developed as partners in this industry. In closing ... welcome to the EMSDIRECTOR!

emsdirector@emergencymedicalsolutionsllc.com

Inspiring Leaders
Serving Their Communities
www.nemsma.org
I’m biased - I’ll admit that - because I believe in what the credentialing process stands for ... enhancing professional development.

As we’re all continually learning, advancing, and growing on our own personal & professional path, we’re fortunate that there are a number of avenues that we can take. Online learning has changed the outlook of our industry toward earning both undergraduate and graduate degrees ... credentialing bodies have emerged and gained respect as standard-setting (and bar-raising) entities ... organizations have actively sought opportunities to grow their own memberships’ options.

As such, NEMSMA - along with its American College of Paramedic Executives (ACPE) affiliation - has equally entered into the market as a strong supporter ... enhancer ... of professional development.

Credentials aren’t designed to take the place of degrees ... they’re designed to enhance them.

Many of us already have a degree in something or the other. My AAS is in Fire Protection, BS is in Fire Science, and Undergraduate Certificate is in Human Resource Management. So, does this mean that I’m not qualified to “run” an EMS organization? How about your BA in Organizational Leadership ... BS in Biology ... MBA in Healthcare Management?

No. It doesn’t mean that at all. Heck, it likely means that you (and I) simply earned our degrees before EMS or paramedicine-specific degrees even existed! Or, we have a “different” big picture in mind.

Even looking forward, many leaders within our industry choose to seek administrative degrees beyond our industry’s title for a number of reasons. Having something to rely back on - some form of “qualifier” that links your knowledge, skills, and abilities back to our industry (directly) - is where credentials come into place.

For those of us seeking to grow ... take that next step ... credentials also offer a consistent baseline sense of knowledge & experience that an actual title would similarly offer. For those that already have a particular title ... credentials validate your knowledge & experience across a consistent platform of other colleagues (candidates) within the industry.

One agency may call you a crew leader, another a lieutenant, and another a project specialist. From a credentialing standpoint, all of these functions have a similar description ... they’re Supervising Paramedic Officers.

This is what I, personally, value within the ACPE’s credentialing process, titles, values, and vision. They’ve developed & outlined a consistent pathway toward recognizing the many different roles, titles, and responsibilities that are placed upon the field and office members within our industry. They’ve enhanced everyone’s current knowledge base and experience level by offering a universally-recognized title ... one that holds the same weight in North Carolina, Wisconsin, Oregon, Nevada, New Hampshire, and Missouri (or even Ontario, New Brunswick, Puerto Rico, or Norway) alike.

Regardless of your current title or role, you - as an individual - are able to “show” your knowledge and experience by owning a consistent, validated, and verified title ... no matter where your career takes you.

You are able to enhance your current degree(s), promote yourself as verified leader, and stand with an esteemed group of colleagues that support a common cause.

Becoming a Supervising Paramedic Officer (SPO), Managing Paramedic Officer (MPO), or Fellow of the American College of Paramedic Executives (FACPE) is showing that you’ve put in the extra work ... work that your degree may not title you with ... work that your job title may not fully explain ... work that your experience doesn’t always outline. You’ve enhanced your professional background and you’re showing others that you are a verified professional within your industry.

Whether you’re doing it to advance your career, add some letters behind your name, validate your current role, take the next big step within your organization, or to simply prepare for the future, becoming credentialed as an industry leader shows that you’re invested in yourself ... our industry.
Every agency has some sort of field orientation process. The worst of these are “ride with an experienced medic for a few shifts, then you are on your own.” Better yet, maybe a new paramedic gets a week as a “third person” observing an actual crew in action. But, how does the agency know that the new employee has seen - never mind mastered - all of what is necessary to perform? And, how does the “preceptor” (and some even call these people “FTO”) know what to show the new employee ... let alone know when the new employee is ready to function independently? Many agencies - in their haste to put “meat in the seat” - don’t much care and rush their new employees into positions for which they are not prepared. Some of them will fail as a result.

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Typical FTO programs end at a prescribed time, or when the FTO (who may not have any training for that responsibility) says that the new employee “is ready.” Both of these are pretty arbitrary. And “is ready” is a pretty imprecise measurement.

Field Training and Evaluation Program

Every day brings a new article about the “national paramedic [1] shortage.” While this is a complex discussion, I boil it down to a couple of simple issues that can be expressed in a single sentence.

**Paramedics are not willing to work for poverty-level wages in agencies that treat them like numbers, rather than valuable members of the team.**

If we could bring all the people holding paramedic licenses out of the clinics, hospitals, schools, and other places they are working - and back to pre-hospital emergency care - there wouldn’t be much of a shortage!

So, how do we get past “treating them like numbers?” One of the ways is through a good on-boarding process. Your new employees are probably already aware that they are not ready to “hit the streets” the day that you hire them. Many have much to learn, as basic-level curricula (for the most part) doesn’t prepare them to drive ambulances, handle complete calls independently, and to do their jobs “the way that we do things around here.”

Every agency is different ... and your new employees will be using equipment that they’ve never seen before. They may never have driven an ambulance ... they may not know where your hospitals are located ... or what is expected of them when they get there.

Once upon a time, an EMS FTEP team developed a motto: “turning paramedics into [AGENCY NAME] paramedics.” At the time, this was accurate. New paramedics were hired with all the knowledge and skills of a paramedic. Later, this changed. It became necessary to re-teach, to a higher level, things that we thought should be learned in paramedic school – ECG interpretation, pharmacology, patient assessment, emergency vehicle operations, lifting & moving patients using modern stretchers. This two-week orientation, over the years, evolved to a 14-week “academy” where much of paramedic school was re-taught. Then, it was off to the field.

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**INSPIRING LEADERS**

Serving Their Communities

www.nemsma.org
If a field training program - or any other system - is used to determine whether a person gets to keep their job, the Equal Employment Opportunity Commission – a federal agency – says that the program is a “test.” Accordingly, it must meet legal standards of “validity” and “reliability.” (2) If it does not, the agency may find itself liable for wrongful termination.

Validity implies the extent to which the test measures what it is intended to measure. Reliability refers to the degree to which the test produces consistent results, when repeated measurements are made (those who pass the program go on to be successful paramedics in the agency, while those that fail would not).

So, how do we get to a valid and reliable program? These are the three principal elements of EMS-FTEP:

First, we develop procedures and tools to assure that every candidate is instructed and evaluated in the same procedures, in a logical progression, to the level of mastery that the agency requires. In EMS-FTEP, the tool is called the “Phase Guide” or “Phased Training Manual,” and is customized to the policies.

Second, we develop a set of measuring standards that are used by all FTOs for all candidates. The agency develops, using a standardized 7-point scale, a set of objective statements for measuring candidate behaviors (interestingly, the biggest challenge in the program is getting FTOs to use the objective grading scale, rather than their own opinions, for evaluating candidates). These are called “Standardized Evaluation Guidelines.”

Third, the agency develops a documentation procedure using either paper, a homemade program, or commercially available FTEP documentation software. Candidate performance is documented, and feedback is provided, before the FTO and candidate go home at the end of the shift.

Additional program components include:

- FTOs that are trained in the proper application of program elements.
- Supervisor involvement, again by supervisors trained in the program. Supervisors evaluate candidates at fixed intervals throughout the program (often every 2 weeks).
- Evaluation by multiple FTOs (usually 3 during the course of the program).
- Communication (and documentation of it) between FTOs at the end of each training phase (when the candidate moves to a new FTO).
- Periodic clinical evaluations, using high-fidelity simulators where possible.
- A final operational evaluation, usually conducted by senior paramedics and supervisors.
- A final clinical evaluation, usually conducted by the medical director and clinical training staff.

When the program is complete, there is a package of program documentation that will support the agency’s decision to retain or release the employee. This package has proven useful in addressing concerns of human resources departments and other outside regulatory authorities.

There is no research directly on point evaluating the value of FTEP in EMS — simply because nobody has ever done the study. However, there is abundant research in the law enforcement community (where many states require the program for law enforcement officer certification), as well as in the nursing community (where the implementation of “residency” programs, rapid response teams, and other supportive procedures and programs have substantially reduced new employee turnover). And, EMS agencies with long experience in the program swear by it.

EMS-FTEP is one of the key educational program offerings of the National EMS Management Association (NEMSMA). For more information, or to get started considering EMS-FTEP for your agency, a quick Google search will yield quite a bit of information. After that, feel free to contact me (I’m the national program chair for NEMSMA) at skirkwood@nemsma.org.

Be safe out there! ♦NEMSMA

SkiKirkwood, MS, JD, NRParRet., FACPE, is the national program chair for the Field Training and Evaluation Program for NEMSMA, and can be reached at skirkwood@nemsma.org.

(1) The author has adopted the international naming convention for EMS personnel, wherein all credentialed prehospital care providers are referred to collectively as “paramedics.”

Advocate - or advocacy - is the theme for this quarter of the EMS DIRECTOR ... so why not incorporate it into the discussion within EMS3i!? 

Looking at insight, in a sense, is like looking at one’s past in order to gleam light into the future (or even one’s present).

Historical trends of accountability, structure, and organization have been cornerstone components of the fire service ... and they’ve been creeping their way into EMS-based EMS agencies over the years as well. This has improved daily operations, provided avenues of professional growth, and incorporated a sense of pride & ownership. Many of these principles will continue to shape our industry as it transitions into “phase 2” of its existence.

In many instances, this is chalked up to tradition - something that the EMS-based industry hasn’t had enough time around the Earth to really establish (or have we?). Tradition ... noticing historical trends (and now basing them on evidence-based practices) ... is, perhaps, more engrained into EMS than we give it credit for. While it may not be the structure or culture that the fire service is known for, we certainly see tradition exemplified in our staffing models, apparatus configurations, and even in our titles (ie: EMT vs. paramedic, etc.).

Nevertheless, looking back ... having insight, now ... brings us (our industry) to its future - our present.

What have we changed over the course of nearly 60 years in existence? What have we advocated for that is now current practice ... current standard - our industry standard?

What do we see on the horizon for tomorrow ... the future?

How has innovation changed our industry thus far, and how will it potentially impact it as we progress forward?

What’s unique about the present is that it was once the future. Who would have thought that we would be marching in the streets and protesting the use of backboards, advocating for a “stay & play” mentality during cardiac arrest resuscitation, or even making the push to limit our use of epinephrine?

All of this (and certainly so much more) has gotten us to today ... the present ... and what was the future.
What has changed our industry for the “today” ... the present? What have we done to promote the integration of our industry into the fields of public safety, emergency preparedness, public health, and healthcare in general?

How has the present played into our MISSION? (Which will be the theme of the 2019Q4 issue)

2019 is surely shaping-up to be an exciting year in our industry’s history. Cost reporting, degrees, titles, reimbursements, transport considerations ... fun stuff, right!?

Let’s make the most of the present ... be it today physically, or even this year. Let’s inspire, inform, and involve each provider, each agency, each association ... our industry ... so that we can gleam insight in an effort to promote innovation, all so that we can become an integrated system.

We’ve all heard the mantra that “if you’ve seen one ambulance service ... then you’ve seen one ambulance service.” Well, I call bullshit! If you’ve “seen one ambulance service,” then I’ll bet that you’ve actually seen about “1000” pretty much just like it! They’ve all (likely) got the same strengths, weaknesses, opportunities, and challenges. Recruitment ... retention ... reimbursement ... employee engagement ... and the list goes on. They’re the same issues facing each agency in the present, so let’s STOP pretending that they’re unique to one individual agency, and start unifying to acknowledge that it’s a systematic issue ... one that was brought about by the past, has affected the future, and is now our present!

Let’s unify, today, so that we don’t try to fix the same problems in the future by simply applying the same techniques & ideas that got us into this mess in the first place! Let’s unify ... integrate ... so that we can leave today and enter tomorrow stronger, all while appreciating our progress from yesterday.

The EMS3i initiative is designed to inspire, inform, and involve EMS professionals by focusing on >insight<, >innovation>, and <integration> of various concepts, practices, and trends within the EMS industry.

Its short articles provide to the EMSDIRECTOR publication an opportunity to spark interest and investment within the EMS industry & community at both the provider & administrative levels ... both as professionals.
VIOLENCE IN HEALTHCARE
... IS IT REALLY AN ISSUE?

If so, what should a training program focus on?

Are assaults on healthcare workers on the rise? Or, is there just more attention being placed on the topic?

No matter what EMS/healthcare trade magazine or website you go to, you will find reports of assaults nearly every single day. Now, you won’t find these assaults on the mainstream news networks, as these events are not considered as “news;” but rather “just part of healthcare workers’ jobs.”

According to a 2013 study by the Bureau of Labor Statistics, there were more than 23,000 serious injuries due to assault at work, with more than 70% of those assaults taking place in the healthcare or social service settings. The study goes on to say that an assault on a healthcare worker is the most common source of non-fatal injury or illness requiring days off from work. But we truly don’t need a “study” to tell us that we are being assaulted at an alarming rate ... just do a Facebook search and there are eight that appear in the last week and a half alone (at the time of writing this article). Now, remind you these are only the ones that have made national news and/or were even reported!

So, what can we do about this alarming rate of assaults to healthcare workers?

We can start by acknowledging that we, as healthcare providers, have lost neutrality. We are now seen as working in the same light as the TV show “Cops.”

“How did this happen,” you ask? Well, we started dressing like “Cops” ... we started acting like “Cops” ... we wear ballistic vests like “Cops” ... and in some places, we even carry guns.

This is my primary reason for why I believe assaults have risen. We have become law enforcement officers! Our job is not to take custody or arrest someone; rather, to offer care. Sounds easy, right?

So, what does “reason defense mean?”

It means using just enough force to be able to escape a situation that is unreasonable. If you work at a store and someone takes a swing at you, that is easy ... they are attacking you. If you work in the healthcare profession in the world that our staff gets attacked ... not defensive in the situations where we do health care requiring days off from work.

We need to understand that offensive without defensive is not protection and in some places, we even wear ballistic vests ... IS IT REALLY AN ISSUE?

So, now that we have recognized that assaults can and will happen, this is where our training program focuses. This might make some forget that our primary purpose is patient care ... so, how do we go from defensive to offensive without reasonable control of people; media, and courts.

But as a doctor, medic, nurse, or an uncooperative patient, we have to determine if this attacker, patient, or the uncooperative patient, or the “attacker,” is having a basic set of physical skills that work more often than not (nothing is 100%) ... that works on both the “uncooperative patient” or the “attacker,”

This is especially true when we are involved in an encounter. Having your head on a swivel at all times (including the second of time an uncooperative patient, or the “attacker,” is uncooperative) is having a basic set of physical skills that work more often than not (nothing is 100%) ... that works on both the “uncooperative patient” or the “attacker,”

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that are reasonable for the amount of force that is being applied against you to escape. Now, we have all heard the sayings “hit them over the head with an O₂ bottle,” “give them the big green pill,” etc. But, is deadly force really the reasonable answer all the time? The answer is NO!

MEDIA

“Media” (which we break down into social media & mainstream media) is understanding that everything that we do is always being filmed. So, how we act, the words that we use ... all have either a positive or negative impact on what others feel that we did (or didn’t do) right. Our goal should be to always look and sound like we are defensive - since at no time did we want to get into this altercation.

COURTS

“Courts” is broken up into two different parts: the court of public opinion and the court of law. Now, the court of public opinion is what your bosses, peers, and the general public all think about your actions. The court of law is the actual criminal or civil courts.

One of the things that you must remember is that the court of public opinion has great influence on the court of law - since juries are made up of your peers. So, one of the things that we need to consider is making sure that we are reporting assaults to both law enforcement as well as to our supervisors. This not only brings awareness to the totality of events that are occurring, but it also helps to end the cycle of violence through criminal prosecution. There is a reason why nearly every state has made it a felony to assault healthcare professionals.

In conclusion, the only way to “win” in the case of an assault is by winning in all four areas as described above. If you win in the “street,” but not in the “media” – because you look like you were beating a “patient” up – you have now also lost in the “court” of public opinion, as well as possibly the court of law.

By training in a program that focuses on more than just a few physical skills, you will hopefully avoid ever being involved in the assault to begin with! But, if a physical altercation does incur, you will hopefully understand what is considered “reasonable”

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EMS CONFERENCE CALENDAR

**abc360**
*Page, Wolfberg & Wirth, LLC*

- **October 19-23, 2019**
  - Hershey, PA
- **March 23-26, 2020**
  - Las Vegas, NV
- **April 5-9, 2020**
  - St. Louis, MO
- **June 7-11, 2020**
  - Clearwater Beach, FL

[www.abc360conference.com](http://www.abc360conference.com)

**Vital Signs 2019 EMS Conference**

- **October 24-27, 2019**
  - Buffalo, NY

[www.vitalsignsconference.com](http://www.vitalsignsconference.com)

**AHEPP Annual 2019 Conference**
*Association of Healthcare Emergency Preparedness Professionals*

- **November 5-7, 2019**
  - Scottsdale, AZ

[www.ahepp.org](http://www.ahepp.org)

**Initial Assessment EMS Conference**

- **May 13-17, 2020**
  - Lake Placid, NY

[www.initialassessmentconference.com](http://www.initialassessmentconference.com)

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Include: event name, sponsor, date(s), location, website

Submissions must be made by an authorized representative of the event in order to be added.

**insight@emergencymedicalsolutionsllc.com**

You can also add your information on our LinkedIn group page:

*EMS Conference Calendar*

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Check out our website to learn more about our **EVE** (Escaping Violent Encounters) line of courses for fire, EMS, healthcare providers, and the general public!
The field of paramedicine is rapidly evolving. This means paramedics must gain a distinct set of skills to serve patients and stay up-to-date on the latest technologies.

Though some initially resisted the idea of a college degree requirement, the EMS and paramedic community could only benefit from this evolution. The majority of paramedics in Kansas and Oregon must earn at least an associate’s degree to be licensed in their state.

A degree requirement would increase employer satisfaction. Departments and individual paramedics would benefit financially from a college degree requirement, and rather than debating this topic, the best next step is to evolve with the times and focus on ensuring a smooth transition.

A degree requirement would result in financial margins. Implementing a college degree requirement for paramedics would increase the value of its workforce and lead to improved patient care.

Three related benefits of implementing a degree requirement are:

- Exercise high-level technical skills
- Excel in their communication
- Provide EMS

Put simply, cur training requirements reflect the demands of the job. In many challenging for research experience, require deep professional knowledge, and will insinuate the characteristics of the paramedic field.

It’s worth noting that in June 2018, roughly 60% of accredited paramedic programs in the United States already require at least an associate’s degree to be licensed in their state.

A degree requirement would increase employer satisfaction. Departments and individual paramedics would benefit financially from a college degree requirement, and rather than debating this topic, the best next step is to evolve with the times and focus on ensuring a smooth transition.

But before we do this, we must recognize that implementing a degree requirement for paramedics may lead to a number of challenges. Here are some suggestions for mitigating them:

- Implement a hybrid model that allows paramedics to return to school part-time.
- Offer alternative options, giving recruits a chance to serve in the field while they pursue their degree.
- Provide non-paramedic f EMS leaders and their ability to recruit or train staff.

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WHY THE DEGREE DEBATE SHOULDN’T BE A DEBATE ANYMORE

JOSHUA A. WORTH, Sr.
EMT P, CADS

As an EMS manager, I started in the field nearly 10 years ago. I remember when I joined, I didn’t care if I had a degree... at least I did. I remember looking at many of my mentors and leaders in the profession, and thinking, “they worked their way up... I really want to do that too.” I recall the call for me to see that 2,000 hours of training would advance the profession is a comprehensive, integrative, and collaborative process that involves all stakeholders and requires a multidisciplinary approach. I realized something was missing from the current educational landscape, all allied health professions require some level of degree to be certified. There are many programs that result in a degree, like lactation consultants, are closely associated with another degree holding professional. The allied medical profession: a degree. The allied medical profession: a degree. The allied medical profession: a degree.

Besides, what was I worrying about? (Student debt, no doubt.) Besides, what would a degree get me anyway? (Training and continuing education we go through is painfully inadequate.) Besides, what was I missing in the weeds of management and leadership of our new medic for command. It only took one my wake up call to see more!

My wake-up call was a new medic for command. It only took one wake-up call for me to see what wasn’t enough to prepare someone with no medical experience to practice any form of medicine. I often attend conferences and seminars for current EMS professionals. There isn’t a conversation about what we need to happen. We need to improve our world, for the sake of the same. We need to be in the forefront of the allied health profession: a degree. The allied medical profession: a degree. The allied medical profession: a degree.

As I grew in the profession and started really getting in the weeds of management and leadership of our new medic for command. It only took one wake-up call for me to see what wasn’t enough to prepare someone with no medical experience to practice any form of medicine. I often attend conferences and seminars for current EMS professionals. There isn’t a conversation about what we need to happen. We need to improve our world, for the sake of the same. We need to be in the forefront of the allied health profession: a degree. The allied medical profession: a degree. The allied medical profession: a degree.

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The 1966 National Academy of Sciences report “Accidents of Modern Society” painted a bleak picture of emergency care. It highlighted deteriorating conditions in ambulances and emergency rooms. Among other things, it noted a lack of emergency rooms in many hospitals and a shortage of medical personnel. The report stated, “It is often a battle simply to find a health provider willing to care for a patient who needs emergency care.”

California has had its own set of challenges in providing emergency care. In 2009, the California Department of Public Health reported that 80% of the state’s EMS caregivers were working for private companies. This was in contrast to the 20% working for public agencies. The median salary for EMTs was $16.59 per hour. However, the private sector counterparts earned an average of $24 per hour, with EMTs earning $22.36 per hour and paramedics earning $24.30 per hour.

The California report stated that most EMS caregivers are low-skilled, part-time workers who lack educational and training opportunities. The agency concluded that the private sector EMS providers have an economic advantage over public agencies, which pay lower wages and offer fewer benefits.

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Paramedics who are not unionized are better paid than their private sector counterparts. However, public sector EMS services generally have lower salaries and benefits. The 2009 National EMS Report states that 40% of EMS caregivers are in the private sector, while 60% are in the public sector. The median salary for EMTs in the public sector was $22.36 per hour, while the median salary for EMTs in the private sector was $24.30 per hour. The median salary for paramedics in the public sector was $26.36 per hour, while the median salary for paramedics in the private sector was $28.30 per hour.

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MICHAEL J. WARD, BS, MGA, MIFaE, FACPE, is adjunct faculty with Emergency Health Services at University of Maryland Baltimore County. Ward retired as a firefighter/paramedic from a Washington, DC, urban county. He was a director of an EMS degree program for a university medical center and ran two hospital-based paramedic services under a management contract. You can contact him at mward0@umbc.edu.


**Enjoy the discussion?**

**Next issue’s FEATURED DISCUSSION will focus on the “paramedic” debate …**

**Should everyone be called a “paramedic?”**

Follow **Tim Nowak, Editor-in-Chief,** on LinkedIn to get the details and join the discussion!

Email your article to: emsdirector@emergencymedicalsolutionsllc.com
Within the industry, there is a vigorous debate about whether there should be a degree requirement for paramedics in the United States. There are respected members of the profession on both sides of this debate.

For the record, I do support an AS degree requirement for entry-level paramedics. If we look at other professions that have moved to a degree requirement, the tangible benefits such as improvements in patient care may also identify other benefits.

Minnesota was the first state to require law enforcement to obtain a college degree before focusing on their major. The benefit to our providers, we should not stop halfway at this. If we are supporting improved education of the officers and for their communities.

We can see the same potential benefit for the officers and for their communities. Educated law enforcement officers, rather than academy-trained, led to improvements that step from the profession we have put together as a paramedic profession.

What degree(s)
If we are supporting our providers, they have to have a degree. An Applied Science program is intended to in and of themselves be more general education than academy education. It should be easily transferred toward a future, and will meet or exceed the technical education needed to enter into the profession as a paramedic in our current state. By the way, it also means programs could maintain a “certificate” course for those who want to become paramedics, and already have a Bachelor’s degree (they may only require a few prerequisites).

In most cases, they ultimately will meet or exceed the technical education needed to enter into the profession as a paramedic in our current state. By the way, it also means programs could maintain a “certificate” course for those who want to become paramedics, and already have a Bachelor’s degree (they may only require a few prerequisites).

In most cases, they should make the same mistake as nursing did bringing in a degree with great professors that have programs in colleges and universities with great programs.

Conclusion
The market won’t support such a move at this time, but we must set a standard. Perhaps, a better version of critical care. The future of our profession is to continue to grow in size and numbers.

For our EMS leaders, there is a vigorous debate about whether there should be a degree requirement for entry-level paramedics. There are respected members of the profession on both sides of this debate. Within the industry, there is a vigorous debate about whether there should be a degree requirement for paramedics in the United States. There are respected members of the profession on both sides of this debate.
A DEGREE OF CONCERN

HENRY M. PIKE

First and foremost, I’m glad that this “debate” is finally here, finally getting the spotlight, and finally being seriously considered!

I’ve spent my entire career promoting education, and now we finally are taking steps toward our identity. I’ve spent my entire career expressing the need to establish our identity. We need to determine who we are, where we are, and “why” we are doing this job.

After that, we can have a discussion about the training and compensation we need for the job.

Should we be required to have degrees? Heck, yes!

We should have had this established into our structure decades ago... before we realized that pennies on the dollar for reimbursement wasn’t a sustainable funding model (which is Economics 101)!

I “blame” the “past” for screwing this up... for putting us in this predicament! It’s not the (present) Millennial’s fault... it’s ours...

I’ve spent my entire career promoting education, and now we finally are taking steps toward our identity.

While I’m not industry (EMS) is still a requiring degree for another time and certain degree... out... the impl requirements for the industry to... whether or not we need degrees... it’s over the timing... but the future education (now) won’t... for the future education (now) won’t... for the future education (now) won’t... for the future education (now) won’t...

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Yes, requiring degrees... there are a few necessary components that we need to fix, first, before we add to our industry (EMS, paramedicine, or whatever industry to... whether or not we need degrees... it’s over the timing... but the future education (now) won’t... for the future education (now) won’t... for the future education (now) won’t... for the future education (now) won’t...

I will say, I tend to lean slightly more toward the idea of requiring degrees. Why? Because of the future... but the future education (now) won’t... for the future education (now) won’t... for the future education (now) won’t... for the future education (now) won’t...

We need to determine our identity.

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We need to establish our identity.

Yes, requiring degrees will help... but there are a few necessary components that we need to fix, first, before we get over the hurdle of requiring degrees.

We need to have more - years of experience in promoting the need for requiring degrees. Why? Because there were years we could have been a voice and push the need for requiring degrees. Why? Because there were years we could have been a voice and push the need for requiring degrees. Why? Because there were years we could have been a voice and push the need for requiring degrees. Why? Because there were years we could have been a voice and push the need for requiring degrees.

I’m glad to see US - are a few necessary components that we need to fix, first, before we get over the hurdle of requiring degrees.

Now, please don’t include the millenials... they are not our future... they are our present. Why? Because there were years we could have been a voice and push the need for requiring degrees. Why? Because there were years we could have been a voice and push the need for requiring degrees. Why? Because there were years we could have been a voice and push the need for requiring degrees. Why? Because there were years we could have been a voice and push the need for requiring degrees.

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There is a huge push among certain groups within EMS to require degrees for new paramedic candidates. It is interesting to wonder why government, organizations, or individuals who are paying the most money for the course, and so are the most affected, are not the ones pushing for degree requirements. The question that I am left to ask is “why?”

Does the expense incurred by the student outweigh the benefit of having a degree? Since there is a reported “paramedic shortage” nationwide, is it really beneficial to the student, why should they sit for their paramedic exam. Consider these facts about student loan debt:

- Total Student Loan Debt: $1.51 trillion
- Total U.S. Borrowers with Student Loan Debt: 44.2 million
- Average Student Loan Balance: $37,172 in 2016
- Interest Rate: 6.8%
- Interest Paid in 2016: $393 in 2016

In 2016, the average interest paid on student loans is $393. A paramedic can sit for their paramedic exam when they graduate, and spend the extra money in college when you get a degree as an HR checkbox (one they will waive for the right candidate, with the right experience).

The National Association of EMS Educators published a position paper where they recommended degree requirement for paramedics:

1. Bachelor’s (or life science for the right candidate, with the right experience)
2. Master’s degrees will be even higher!

Several stakeholders have published papers supporting the requirement in EMS:

- The International Association of Fire Chiefs (IAFC) and International Association of Flight and Critical Care Paramedics (IAFCCP)
- The National Association of EMS Educators (NAEMSE), the National EMS Management Association (NEMSMA), and the Emergency Medical Solutions, LLC
- The Plumbers and other organizations.

WHAT SHOULD THE DEGREE BE?

Should we grandfather in existing paramedics? Should the requirement be that the degree is an associate’s or bachelor’s degree? Several paramedics have gone through paramedic programs and then that means that the education for paramedics?

The International Association of Fire Chiefs (IAFC) published a position paper supporting the requirement in EMS. They also argue that more general education graduates don’t necessarily equate to a better paramedic provider. They

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aren’t wrong; the belief that more education leads to better paramedics is an unproven claim, has zero factual evidence behind it, and there has been no research on this topic.

WHERE WE SHOULD SEE DEGREES IN EMS

I don’t think a degree is needed to obtain an entry level position in EMS. I believe that the basic education and training set forth in the appropriate curriculum, whatever that may be, is what is needed to reach entry level qualifications. And while it is true that having a degree could help someone obtain an entry level position, it is not an absolute requirement.

I would, however, support a mandatory requirement for EMS-related degrees for all new hires, and for the renewal of their certifications. This would result in the industry, real world practical application, and continuing education commitments required.

If they want to become critical care paramedics, then they need to further their education, here, coupled with practical experience. This could lead to them gaining experience in the new field. If they want to become critical care paramedics, then they need to further their education, here, coupled with practical experience. This could lead to them gaining experience in the new field.

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EDITOR’S NOTES

Exciting Updates, Progress

TIM NOWAK
AAS, BS, NRP, CCEMT-P, SPO, MPO, CADS
Editor-in-Chief

I’ve become more and more proud of this magazine with each issue!

What started as a mechanism to build the discussion of promoting Professional Development for EMS – particularly with a small, local client base – has grown into a multi-state (even multi-nation) magazine that has a growing subscriber base ... largely in part to a new partnership with the National EMS Management Association.

20 pages turned into 24, then 32, followed by 40, and now 60 pages (with a projected increase to 80 in the near future!).

When some publication and media avenues have abandoned print and have been consumed by digital options, I’ve fought (up-hill, both ways!) to keep print alive! By no means is this magazine at the stature or reputation of JEMS or EMS World (yet!) ... but its growing ... filling a niche that has not otherwise received the representation that it deserves throughout the entire industry (but I have hope!).

This magazine, as you’ve read, is not here to focus on clinical aspects of EMS - paramedicine. Rather, it’s here to focus on professional development for current, growing, and aspiring leaders within our industry.

I’ll be honest ... I read every article in this magazine not just because I have to edit each and every one of them (spending > 100 hours on each issue) ... but because I want to take-in the knowledge, advice, insights, perspectives, and successes of others. I, too, want to learn ... grow professionally.

At the very least, that’s what I want you to get out of this magazine ... to see it as a true advocate for you.

Along with that, here’s my ask - my request - please share.

Share this magazine with your colleagues, subordinates, crew members, partners, teammates, staff, and students. Share your experiences, research, advice, insights, perspectives, and thoughts. Write an article, post on my LinkedIn feeds, and subscribe your agency.

Ambition has been my driving factor behind producing this magazine thus far ... and it will certainly continue to be a driving factor in the future (I’ve got a lot of it!). Your support, moreover, will help to build this magazine even stronger, make it more robust, and will develop it into an industry leader ... an industry standard ... for all EMS directors, chiefs, training officers, quality assurance specialists, medical directors, administrators, and leaders to subscribe to and read - from cover-to-cover.

There’s my transparency ... my goal ... my ambition. It’s quite lofty, I know! But, as our industry rapidly changes (2019 is quite an exciting year!), I want to make sure that you’re able to get solid, progressive, inciteful information directly into your hands (yes, this magazine intends to stay in paper!).

Just as the EMS3i section of this magazine promotes ... I want insight, innovation, and integration to be at the forefront of this magazine (and our industry). In order to do that, I ask for your support.

I welcome you to the challenge, progress, growth, and development that is the EMSDIRECTOR.

Tim Nowak, Editor-in-Chief
advocate

one who supports or promotes the interests of a cause or group; to support or argue for

Merriam-Webster