AMERICAN COLLEGE OF PARAMEDICS
Paramedicine, Led by Paramedics
23 W Central Entrance, PMB 321 · Duluth, MN 55811
americanparamedics.org

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National EMS Advisory Council (NEMSAC)
1200 New Jersey Avenue, SE
Washington, DC 20590

Re: American College of Paramedics Institutional Positions for Incoming NEMSAC — Professionalization, Scope Reform, and Workforce Sustainability

To the Members of the National EMS Advisory Council:

The American College of Paramedics (ACP) submits this public comment to orient newly constituted NEMSAC members to the advocacy positions of the profession's institutional body and to present specific asks for federal attention and action. We write at a moment that is simultaneously a crisis and an opportunity. The structural failures of American EMS — workforce instability, inadequate education standards, an emergency-department-first practice model that no longer serves patients or systems, and chronic neglect of paramedic professional health — are not new problems. They are the accumulated consequence of a system that was never designed. The question before this Council is not whether these failures are real. The question is whether the federal government, in partnership with the profession, is prepared to act with the institutional seriousness these failures require.

I. WHO WE ARE AND WHY IT MATTERS

The American College of Paramedics is the institutional body of the paramedic profession in the United States. For members of this Council who come primarily from medicine, nursing, or emergency management backgrounds, the closest analogues are the American College of Emergency Physicians, the American College of Surgeons, or the American College of Nurse Practitioners. These organizations serve their professions not as labor unions or trade associations, but as the institutional infrastructure through which a clinical profession governs itself: setting standards, developing and adopting positions on clinical and policy questions, engaging federal bodies and legislative processes, and providing the organizational continuity that individual practitioners, agencies, and state systems cannot. The American College of Paramedics serves the same function for paramedicine. We are the body through which the profession speaks with a single institutional voice on the structural questions that no individual agency, state EMS office, or academic center can answer alone.

Members of this Council are likely familiar with the National Association of Emergency Medical Technicians, which represents the EMT and paramedic workforce as a member organization, and with the National Association of State EMS Officials, which represents state EMS regulatory bodies. The American College of Emergency Physicians maintains an EMS section that engages physician medical directors in EMS policy. ACP is distinct from all three. We are not a membership association for individual practitioners, a regulatory body, or a physician organization with an EMS interest. We are the profession's college: the body whose specific institutional purpose is to define what the profession stands for, to establish and advance its standards, and to represent its institutional interests before

federal bodies, policymakers, and the public. The distinction matters because the asks in this letter are not workforce asks or regulatory asks. They are profession-design asks — questions about what paramedicine is, what it should be, and what federal action is required to close the gap between those two things. Paramedics occupy a position in American health care that has no true parallel. They function as autonomous clinical decision-makers in environments where no other licensed clinician is present, operating under physician medical direction frameworks that are designed to authorize population-level rather than individual encounter-level judgment — a structure that recognizes, in practice if not always in formal designation, that the paramedic is making independent clinical decisions in real time. They assess, treat, and increasingly discharge or redirect patients across the full spectrum of acuity, from immediately life-threatening emergencies to complex social and behavioral health presentations. The clinical competence this requires is substantial. The professional infrastructure supporting it is, by comparison, thin.

This is the central argument the American College of Paramedics brings before NEMSAC: paramedicine has matured clinically without commensurate maturation in governance, education, credentialing, or workforce infrastructure. Closing that gap is not a professional preference. It is a patient safety and public health obligation.

II. THE PROFESSIONALIZATION ARGUMENT

Professionalization is a governance argument, not a self-interest argument. A profession is defined by the presence of a defined body of knowledge, standardized education that reliably transmits that knowledge, credentialing systems that verify its acquisition, and institutional infrastructure that maintains and advances standards over time. By those criteria, American paramedicine is partially professionalized at best.

The education system produces competent emergency responders. It does not reliably produce clinicians equipped for the full scope of what paramedics are now asked to do: community health navigation, behavioral health first response, treat-in-place and treat-and-divert decision-making, care coordination with primary care and hospital systems, and an expanding role as first-line responders to the social determinants of health in populations the formal health care system reaches inconsistently. The scope has expanded. The educational foundation has not kept pace.

The credentialing system is state-administered, fragmented, and produces wide jurisdictional variation in what a “paramedic” means in practice. The EMS Compact has meaningfully improved interstate licensure recognition among its member states, but Compact participation is not universal, and the Compact addresses portability of the credential without resolving the underlying problem: there is no shared national definition of what a paramedic is competent to do. A paramedic holding an identical certificate in two Compact states may practice under substantially different scope frameworks depending on state protocols, medical director preferences, and agency policy. A community paramedic practicing chronic disease management in Minnesota operates under a framework that does not exist in most of the country. An emergency medical technician and a paramedic are treated as points on a single continuum in federal data and policy, despite representing fundamentally different clinical roles.

The professional infrastructure — the institutional bodies, governance structures, and policy frameworks that maintain and advance profession-wide standards — is underdeveloped relative to nursing, medicine, and physical therapy. The American College of Paramedics exists to address this gap, but institutional maturity takes time and requires federal partnership that has historically been inconsistent.

NEMSAC has both the standing and the obligation to accelerate this work. The asks that follow are specific, actionable, and grounded in what other health professions have already accomplished.

III. SCOPE OF PRACTICE: THE PRACTICE MODEL MUST BE INVERTED

The foundational design assumption of American EMS — that the appropriate response to an emergency call is transport to an emergency department — is clinically obsolete for a substantial portion of the calls that generate it. Emergency department crowding, ambulance diversion, rural hospital closure, and the growth of behavioral and social health presentations have together produced a system in which defaulting to ED transport frequently produces worse outcomes than the alternatives, including treatment in place, transport to alternative destinations, and structured referral to community-based care.

The American College of Paramedics advocates for a formal inversion of the default practice model. Community paramedicine, treat-in-place (TIP), and treat-and-divert (TAD) models should be recognized as the design center of modern EMS system architecture — not add-ons or experimental programs, but the standard framework within which emergency transport is one option among several, indicated when the clinical picture requires it. This requires federal action on three fronts.

Regulatory Recognition

FICEMS should formally recognize community paramedicine, TIP, and TAD as core EMS service categories, establishing the federal definitional and regulatory framework necessary for consistent state adoption and Medicaid reimbursement. Without federal definition, these models remain dependent on state-by-state legislative action and payer-by-payer negotiation, producing the current patchwork.

Reimbursement Reform

Medicare and Medicaid reimbursement structures that pay only for transport to an emergency department are the single largest structural barrier to modernizing the EMS practice model. The American College of Paramedics urges NEMSAC to recommend that FICEMS and CMS pursue permanent reimbursement pathways for TIP and TAD encounters, building on the experience of ET3 and community paramedicine demonstration programs to establish sustainable funding that does not require emergency department contact as a condition of payment.

Distinct Scope Pathways

The profession includes a large and underserved population of volunteer, fire-based, and rural providers whose operational context differs substantially from the high-performing rural or urban career paramedic for whom most training and scope frameworks are designed. NEMSAC should recognize the need for distinct scope and education pathways that match provider context — including

austere environment providers operating without physician backup — rather than applying a single framework that fails both ends of the operational spectrum.

IV. COMMUNITY PARAMEDICINE, TIP, AND TAD AS SYSTEM DESIGN

The United States will not solve its rural health access crisis, its behavioral health crisis, or its emergency department capacity crisis by building more emergency departments or training more emergency physicians. It will solve those crises, if it solves them, by deploying the clinical infrastructure that is already present in every community — often the only clinical infrastructure in communities where hospitals have closed, and primary care is unavailable.

That infrastructure is the paramedic workforce. Paramedics are in every county in the United States. They are licensed, supervised, and trusted by the communities they serve. They are already responding to the calls that reflect these crises: the mental health emergencies, the substance use presentations, the chronic disease exacerbations, the fall patients in rural homes who have no primary care physician and no family within driving distance. The question is not whether paramedics are doing this work. They are. The question is whether the system will support them in doing it well.

Community paramedicine programs have demonstrated in dozens of communities that structured, protocol-driven paramedic practice outside the emergency response context reduces preventable emergency department visits, reduces hospital readmissions, improves chronic disease management, and produces meaningful cost savings. These are not small effects. Evaluations of community paramedicine programs in Texas, North Carolina, and elsewhere have shown 30-day readmission reductions of 20 to 40 percent in targeted populations. The evidence base is strongest where CP programs operate as genuinely interdisciplinary care models — where the community paramedic functions as a member of a coordinated care team alongside primary care physicians, behavioral health clinicians, social workers, and care coordinators, with structured referral pathways and shared information systems. This interdisciplinary architecture is what distinguishes high-performing CP programs from paramedics operating in isolation, and it requires active physician collaboration in program design, protocol development, and ongoing clinical governance. What the evidence does not show is any sustainable federal funding mechanism that allows these programs to scale.

The American College of Paramedics urges NEMSAC to treat community paramedicine, TIP, and TAD not as programs requiring continued evaluation, but as established care models requiring federal infrastructure investment. Specifically:

- Federal definition of community paramedicine as a recognized health care service category, with minimum competency and supervision standards
- Permanent Medicaid and Medicare reimbursement for community paramedicine, TIP, and TAD encounters that meet defined quality and documentation standards
- Federal guidance directing state EMS offices to incorporate community paramedicine program standards into EMS system regulation
- Investment in workforce training and certification infrastructure for community paramedic specialization, including curriculum standards that can be adopted uniformly across states

The emergency department must stop functioning as the default destination for every call that generates paramedic response. That requires more than paramedic training. It requires active

physician collaboration in protocol development, medical director engagement in community health system design, the destination agreements with community health organizations, and the payer structures that make treatment and diversion clinically safe and financially sustainable. Paramedics are already making these decisions autonomously in the field. Federal leadership is necessary to build the systemic infrastructure that supports those decisions at scale. NEMSAC should say so plainly.

V. EDUCATION: THE FOUNDATION MUST BE REBUILT

The National EMS Education Standards, last substantively revised in 2009, define a minimum competency floor. They do not define a professional education standard adequate to the clinical reality paramedics now face. The American College of Paramedics has adopted the position that baccalaureate-level education should be the baseline professional credential for the career paramedic, with graduate preparation for specialty and advanced practice roles.

This is not a novel position. Every other clinical health profession that now exercises independent judgment — nursing, physical therapy, occupational therapy, pharmacy — has moved to degree-level entry preparation over the past four decades. Paramedicine has not. The result is a profession whose practitioners are performing degree-level clinical work under certificate-level educational authorization.

The Case for an American Paramedic Competence Framework

The American College of Paramedics calls on FICEMS and NEMSAC to support the development of a national American Paramedic Competence Framework, modeled on frameworks already operational in comparable health systems.

Canada provides the most directly applicable precedent. The Canadian Organization of Paramedic Regulators (COPR) has published Pan-Canadian Essential Regulatory Requirements (PERRs) for the Primary Care Paramedic, the Advanced Care Paramedic, and the Critical Care Paramedic designations (2023, revised 2024). These frameworks are structurally equivalent to the CanMEDS Physician Competency Framework adapted for the paramedic profession, and they organize paramedic competence across eight integrated domains: Professionalism; Patient- and Community-Centered Communication; Integrated Collaborative Health Care; Continuous Learning and Adapting to Evidence; Health of Professional; Advocacy for Health, Equity, and Justice; Leadership; and Care Along a Health and Social Continuum.

Critically, the COPR frameworks apply the same eight-domain architecture at the PCP, ACP, and CCP designation levels, with scope-appropriate depth and entry-to-practice skill expectations calibrated to each designation. This means the framework is not a single credential standard but a tiered structure that can accommodate the full range of paramedic designations — from basic life support provider through advanced care provider through specialist and advanced practice roles — within a coherent competency architecture.

The United States has no equivalent. What we have is a patchwork of state-level scope documents, a federal curriculum standard that does not map to competency domains, and National Registry examinations that measure minimum entry-level competency without providing the profession or its regulators with a framework for career-long professional development and practice standards.

An American Paramedic Competence Framework would accomplish several things the current architecture cannot:

- Define what competent paramedic practice looks like across the career span, not only at entry
- Provide the educational infrastructure — accreditation standards, curriculum frameworks, continuing education requirements — that flows from a defined competency architecture
- Create the foundation for reciprocity and interstate practice recognition, which currently fails because states have no shared definition of what a paramedic is competent to do
- Enable meaningful quality measurement, because quality metrics require a competency standard against which to measure
- Support the development of Advanced Practice Paramedic as a recognized practice tier, analogous to the nurse practitioner or physician assistant, filling the prehospital and community-based advanced practice gap that neither NPs nor PAs were trained to fill

The Health of Professional domain in the COPR framework is particularly instructive for the American context. The PCP, ACP, and CCP frameworks include explicit competency requirements for paramedics to understand occupational health risks, recognize the impact of organizational and sociocultural factors on personal health, develop and maintain personal health monitoring practices, and support colleague wellbeing. This is not a wellness amenity. It is a professional competency standard. The Canadian framework treats the health of the practitioner as foundational to safe practice, not as an ancillary benefit program. An American framework should do the same.
The American College of Paramedics requests that NEMSAC recommend FICEMS commission a national work group, with ACP participation, to develop an American Paramedic Competence Framework using the COPR PERRs and comparable international frameworks as primary reference documents.

VI. WORKFORCE INFRASTRUCTURE: PHYSICAL HEALTH, PSYCHOLOGICAL HEALTH, AND CAREER SUSTAINABILITY

Paramedicine has a workforce health crisis that the profession has described, documented, and failed to structurally address for decades. The American College of Paramedics is prepared to be precise about what “structurally address” means, because the distinction between structural response and programmatic response is the central failure of every previous effort.

Physical Health

EMS is among the most physically hazardous occupations in American health care. Injury rates, musculoskeletal damage, cardiovascular disease prevalence, and early career attrition attributable to physical injury are documented across multiple datasets. The profession does not routinely require pre-employment physical fitness standards, does not invest in injury-prevention engineering for patient handling and lifting, and does not systematically track cumulative physical injury across careers. A 30-year paramedic career, by the physical demands currently imposed, is not reliably sustainable for most practitioners.

The American College of Paramedics urges NEMSAC to recommend federal standards for EMS physical health infrastructure, including validated pre-employment fitness standards scaled to operational context, injury tracking and reporting requirements, and investment in patient handling

technology and training that reduces musculoskeletal injury rates. This is occupational safety, not wellness.

Psychological Health and Peer Support
The behavioral health burden of paramedic practice — occupational stress injury, post-traumatic stress, moral injury, and the chronic psychological effects of repeated high-acuity exposure — is well-documented and chronically underfunded. The available evidence supports the following conclusions: peer support programs supervised by licensed behavioral health clinicians reduce crisis presentation and improve help-seeking; pre-employment behavioral health screening identifies protective and vulnerability factors that can inform deployment and support planning; and post-career behavioral health care is nearly absent in American EMS.

The American College of Paramedics advocates for regional peer support teams as a standard EMS system element, not a department-by-department amenity. Regional teams, supervised by licensed clinicians, can serve agencies too small to support their own programs. This is the model that exists in some international EMS systems and that the evidence supports. Federal funding through HRSA or SAMHSA could establish regional peer support infrastructure in rural and frontier areas where individual agency capacity is insufficient.

We further urge NEMSAC to support designation of paramedic workforce physical and psychological health infrastructure as the 16th element of an EMS system — a formal recognition that workforce sustainability is a component of system design, not an afterthought. Without a workforce, there is no system.

Post-Career Care
The American health care system has no organized mechanism for addressing the long-term health consequences of paramedic careers. Firefighters have occupational cancer registries and presumptive benefit legislation in most states. Police have line-of-duty death benefits and disability frameworks. Paramedics, who carry comparable or greater biological hazard exposure and similar cumulative psychological burden, have neither. The American College of Paramedics urges NEMSAC to recommend that FICEMS work with NIOSH, HRSA, and VA to characterize the long-term health burden of paramedic careers and develop federal policy frameworks for post-career care.

VII. RURAL EMS: ENGAGE THE PROFESSION'S INSTITUTIONAL BODY
Rural EMS system failure is not primarily a funding problem, though funding is inadequate. It is a governance problem. Rural communities lack the administrative infrastructure to design, procure, oversee, and sustain EMS systems. County governments that could not organize a health department are being asked to govern advanced life support delivery across jurisdictions spanning hundreds of square miles. The results are predictable.

Ambulance deserts — geographic areas in which EMS response times exceed 30 minutes or in which no organized EMS system exists — affect an estimated 4.5 million Americans across 41 states, including a substantial proportion in non-rural settings. The Federal Office of Rural Health Policy, HRSA, and the Health Resources and Services Administration have all identified rural EMS sustainability as a priority. Federal investment has followed. What has not followed is a systematic

effort to engage the profession's institutional body — the American College of Paramedics — in the design of rural health system responses that include and center the paramedic workforce.

The American College of Paramedics requests a formal role in FICEMS deliberations on rural EMS system design, including participation in federal rural health advisory structures, inclusion in Health Resources and Services Administration rural health grant program design, and standing engagement with HRSA's rural EMS advisory infrastructure. The profession has both the operational expertise and the institutional standing to contribute to rural system design at a level that exceeds what any individual state, agency, or academic center can provide.

Community paramedicine, in particular, represents an essential tool for rural health system resilience. A community paramedic embedded in a rural or frontier community can perform the chronic disease monitoring, preventive health intervention, behavioral health navigation, and social needs assessment that would otherwise require primary care access that does not exist. This is not a supplemental service. In communities without primary care, it may be the primary service. Federal rural health investment should reflect that reality.

VIII. CONCLUSION AND SUMMARY OF REQUESTS

The American College of Paramedics submits the following specific requests for NEMSAC action and recommendation to FICEMS:

1. Scope and Practice Model

- Direct FICEMS to formally recognize community paramedicine, treat-in-place, and treat-and-divert as core EMS service categories with federal definitional standards
- Recommend CMS pursue permanent Medicare and Medicaid reimbursement pathways for TIP and TAD encounters
- Recognize and support a distinct vocational and employer-based education pathway for volunteer, fire-based, non-transport, all-hazards, and austere environment providers, paired with a commensurate scope of practice appropriate to their operational context

2. Education and Competency Framework

- Recommend FICEMS commission a national American Paramedic Competence Framework work group, with ACP participation, using the COPR PERRs frameworks as primary reference
- Endorse baccalaureate-level education as the federal standard for career professional paramedic practice, with graduate preparation for specialty and advanced practice roles
- Recommend FICEMS direct the National EMS Education Standards revision process to align with a competency-domain architecture rather than skill-list enumeration
- Recommend federal recognition of Advanced Practice Paramedic as a formal practice tier, with scope standards and reimbursement pathways

3. Workforce Health and Infrastructure

- Recommend federal EMS physical health infrastructure standards including validated pre-employment fitness standards and injury tracking requirements
- Recommend HRSA and SAMHSA funding for regional EMS peer support programs supervised by licensed behavioral health clinicians, with priority to rural and frontier areas

- Recommend designation of paramedic workforce physical and psychological health infrastructure as the 16th element of an EMS system
- Recommend FICEMS work with NIOSH, HRSA, and VA to characterize long-term paramedic career health burden and develop post-career care policy frameworks

4. Rural EMS and Institutional Engagement

- Provide the American College of Paramedics a formal advisory role in FICEMS rural EMS deliberations
- Include ACP in federal rural health grant program design through HRSA
- Recognize community paramedicine as a primary rural health service category in HRSA rural health policy frameworks

The American College of Paramedics is available to brief NEMSAC members, contribute to workgroup deliberations, or provide additional written materials on any of the issues raised in this comment. We welcome direct engagement with this Council and with FICEMS as you undertake the work of advising federal EMS policy for the years ahead.

Respectfully submitted,

Nikiah G. Nudell, PhD(c), MS, MPhil, NRP, WP-C
Chairman, American College of Paramedics
Paramedic Scientist, The Paramedic Foundation

cc: Clary Mole, NHTSA Office of EMS