NEMSQA
National EMS Quality Alliance

# 2025 Measures Report

## Measuring What Matters in Prehospital Trauma


**Prepared by**
NEMSQA Measure Analysis
& Research Committee

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# About NEMSQA

The National EMS Quality Alliance (NEMSQA) is the nation's leader in the development and endorsement of evidence-based quality measures for Emergency Medical Services (EMS). Formed in 2019, NEMSQA is an independent non-profit organization comprised of stakeholders from national EMS organizations, federal agencies, EMS system leaders and providers, EMS quality improvement and data experts as well as those who support prehospital care with the goal to improve EMS systems of care, patient outcomes, provider safety and well-being on a national level.

## Post-Crash Care

In 2024, NEMSQA launched a major initiative to strengthen post-crash trauma care by developing new evidence-based performance measures. The project leverages the National EMS Information System (NEMSIS) to evaluate how EMS agencies deliver care in the field, supporting NHTSA's Office of EMS priority to improve EMS participation and engagement in clinical and system performance measures focused on evaluating processes, services, and care provided after a Motor Vehicle Crash (MVC). The goal was to create standardized measures that allow EMS organizations and clinicians to benchmark their performance against peer agencies, state values, and national norms.

The work followed NEMSQA's established measure development process: identifying candidate concepts from evidence-based guidelines, prioritizing them through objective scoring and expert consensus, and building detailed specifications and pseudocode for implementation and testing to ensure feasibility and reliability.

Importantly, the measures that scored highest were fundamental trauma care measures, not HALO (high-acuity, low occurrence) measures. While some HALO measures were developed, they are unlikely to be used for quality improvement at the agency level due to limited case volume. This distinction underscores that post-crash care is, at its core, trauma care–the mechanism of injury may be a motor vehicle crash, but the same trauma fundamentals apply.

By focusing on post-crash trauma care, this project addresses one of the leading causes of morbidity and mortality nationwide. It represents a unified national effort to translate evidence-based trauma guidelines into actionable measures, enabling EMS systems to improve patient outcomes, enhance accountability, and strengthen their role in the trauma care continuum.

# Measure Focus 2025

# Trauma

**High-Impact, High-Frequency Measures in Prehospital Care**

In trauma care, it is often the rare, high-stakes interventions–surgical airways, needle decompressions, or prehospital blood transfusions–that capture attention. These high-acuity, low-occurrence (HALO) skills are dramatic, technically demanding, and can carry immense consequences when performed. Yet the data consistently show that they are performed infrequently in the field. While HALO procedures remain essential components of a comprehensive trauma capability, they are not what defines excellence in trauma care.

The true measure of quality lies in the bread and butter of trauma care–the high-frequency, high-impact practices that every EMS provider performs daily. Preventing hypotension, hypoxia, and hypothermia is what consistently moves the needle for patient outcomes. These fundamentals are the real work of trauma teams, requiring vigilance, precision, and consistent execution under pressure.

**Rare Interventions, Real Consequences**

HALO procedures such as prehospital blood administration, tranexamic acid (TXA), tourniquet use, intraosseous access, and needle thoracostomy remain important, but their rarity makes them difficult to sustain in practice. Evidence shows that while some interventions–like blood transfusion or TXA–can improve survival when used appropriately, barriers such as logistics, training, and scope-of-practice restrictions limit their widespread adoption. Others, such as pelvic compression devices or hemostatic dressings, show mixed or limited evidence of benefit.

These interventions highlight the paradox of trauma care: dramatic procedures may save lives in rare circumstances, but they cannot be the foundation of quality improvement. Their infrequency underscores the need for ongoing training, simulation, and quality oversight to ensure readiness when minutes matter.

**The Fundamentals That Drive Outcomes**

By contrast, the core principles of trauma care–airway management, bleeding control, and vigilant monitoring of vital signs–are performed every day and directly impact survival. Documenting blood pressure, respiratory rate, and Glasgow Coma Scale; preventing hypoxia and hypotension in traumatic brain injury; ensuring patients are transported to trauma-capable hospitals; and initiating trauma alerts early are all examples of measures that define system excellence.

These practices may lack the drama of HALO skills, but they are the interventions that consistently save lives. They represent the disciplined, routine work of trauma teams: taking vital signs, applying tourniquets correctly, maintaining normothermia, and communicating effectively with receiving hospitals.

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# Measure Focus 2025

## Trauma

**Under Pressure When Seconds Count**

The message of this year's report is clear: trauma care isn't about rare heroics–it's about consistent execution of the basics. HALO procedures will always have their place, but the fundamentals–preventing hypotension, hypoxia, and hypothermia–are what drive outcomes across thousands of patients every day.

Maintaining readiness for rare interventions is important, but excellence in trauma care is defined by how reliably teams perform the basics under pressure. Ongoing education, simulation, and adherence to quality-improvement programs ensure that providers remain proficient in both routine and rare interventions. By reinforcing the importance of high-frequency, high-impact measures, we can continue to advance trauma care and improve survival for patients across the nation.

| HALO Interventions | Frequency | Percent |
|---|---|---|
| Invasive Airway | 24,390 | 0.48% |
| Tourniquet | 14,320 | 0.28% |
| Traction Splint | 7,028 | 0.14% |
| Pneumothorax Relief | 3,688 | 0.07% |
| Cricothyrotomy | 142 | <0.01% |
| Pressure Trouser | 45 | <0.01% |

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# Quality Metrics
## Measure Top-Out

When reviewing this report, you may notice that a couple measures–such as Trauma-08 and TBI-01–show performance rates above 90%. At first glance, these results might appear "topped-out," raising the question of whether they remain meaningful for improvement. However, even when national performance looks exceptionally high, there is a formal process for determining true "top-out" status.

**What is a process measure?**
A process measure evaluates whether a specific clinical action was taken–for example, administering the correct medication or completing a timely screening. In alignment with CMS standards, a NEMSQA process measure is considered topped-out when the median performance rate exceeds 95% across providers and agencies.

**Ensuring statistical validity**
To maintain accuracy and fairness, only entities with at least 20 encounters or patients in the measure's denominator are included in the analysis. This minimum case count ensures that results reflect consistent performance rather than chance variation.

**Why high performance doesn't equal retirement**
Reaching the >95% median threshold does not automatically lead to a measure's retirement. Before any decision is made, epidemiological data are carefully reviewed to determine whether meaningful gaps in care persist–particularly within specific patient populations. High overall performance does not necessarily mean the underlying health issue has been resolved. Ongoing monitoring helps confirm whether the measure continues to serve as a valuable tool for quality improvement.

**Summary**
- A process measure is considered topped-out when providers/agencies with more than 20 eligible encounters achieve a median performance rate above 95%.
- Even then, further review of public health and performance data is required before retirement is considered.
- For non-process measures (such as outcome measures), more complex statistical criteria apply. Currently, none of NEMSQA's non-process measures are close to meeting those thresholds.

### What is a "Topped Out" Process Measure?

A process measure is considered "topped-out" when the median performance rate is >95% across providers and agencies.

### Why 20 Cases Matter

Only providers and agencies with 20 or more encounters/patients in the measure's denominator are included in the top-out analysis, ensuring that results are statistically meaningful and not based on small sample sizes.

### Top Performance Does Not Equal Measure Retirement

Reaching >95% does not automatically lead to a measure's retirement. Epidemiological data reviews determine if care gaps still exist, especially for underserved populations.

### Ongoing Relevance of Quality Measures

Even if a measure is "topped-out" it may still be relevant. Epidemiological analysis determines if the measure is needed to continue addressing a pressing need.

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# Measure Details

| Measure Name | Description |
|---|---|
| **Trauma-08** | Percentage of EMS transports originating from a 911 request for patients with trauma during which GCS (motor), systolic blood pressure, respiratory rate, pulse rate, and pulse oximetry are documented. |
| **Trauma-04** | Percentage of EMS transports originating from a 911 request for patients who meet ACS prehospital field triage criteria who are transported to a trauma center. |
| **Trauma-14** | Percentage of EMS transports originating from a 911 request for patients who meet ACS prehospital field triage criteria for whom a pre-arrival trauma alert or activation is initiated. |
| **TBI-01** | Percentage of EMS transports originating from a 911 request for patients with suspected traumatic brain injury during which oxygen level, ETCO2, and systolic blood pressure are documented. |

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# Measure Performance

| Measure | Adult | Pediatric |
|---|---|---|
| **Trauma-08** | 93.5% | 85.1% |
| **Trauma-04** | 26.0% | 25.7% |
| **Trauma-14** | 11.0% | 11.4% |
| **TBI-01** | 92.7% | 85.7% |

NEMSQA Measure Technical Documents

# Trauma-08

## *Vital Signs as the Foundation of Trauma Assessment*

Trauma-08 tracks the percentage of EMS transports for trauma patients–originating from a 911 request–during which five key vital signs are documented: Glasgow Coma Score (motor), systolic blood pressure, respiratory rate, pulse rate, and pulse oximetry. These components are not just routine–they are foundational to trauma assessment and triage, especially as defined by the American College of Surgeons (ACS) Field Triage Guidelines. [2,3]

Vital signs are the first indicators of physiologic compromise. They guide decisions about trauma center destination, activation of trauma teams, and early interventions that can save lives. Whether identifying hypotension in a patient with suspected hemorrhage or recognizing altered mental status in a head-injured patient, these metrics are central to the prehospital evaluation of injury severity. Their consistent documentation reflects not only clinical vigilance but also system readiness.

**Performance Snapshot**

- Adult patients: 93.5% of trauma transports included documentation of all five vital signs.
- Pediatric patients: Performance drops to 85.1%, with the most notable gaps in systolic blood pressure (89.7%) and pulse oximetry (92.3%).

While adult performance is approaching a "topped out" threshold nationally, pediatric documentation–particularly in younger age groups–remains an area for improvement. These gaps may reflect challenges in obtaining accurate readings in small children, competing clinical priorities during high-acuity scenes, or limitations in equipment and training. They may also signal broader system-level issues, such as variability in pediatric protocols or documentation workflows.

**Why This Measure Still Matters**

Even as adult performance nears saturation, Trauma-08 remains a critical measure. It reinforces the importance of complete trauma assessments and provides a benchmark for system accountability. For pediatric patients, it highlights where targeted education, equipment updates, or protocol refinements could close documentation gaps and improve care.

Trauma-08 is more than a checkbox–it's a reflection of how reliably EMS systems capture the data that drives triage, treatment, and outcomes. As trauma systems evolve, this measure continues to serve as a bellwether for clinical quality and operational excellence.

| | Numerator | Denominator | Performance |
|---|---|---|---|
| Adults | 4,412,281 | 4,720,533 | 93.5% |
| Pediatrics | 314,290 | 369,193 | 85.1% |

# Trauma-04 &Trauma-14

## *Aligning documentation with reality to strengthen trauma system performance*

The 2025 NEMSQA Annual Report continues its focus on prehospital trauma quality, emphasizing the fundamentals of system development, patient safety, and integration with hospital-based trauma care. Two measures—Trauma-04 and Trauma-14—highlight critical aspects of EMS system performance: ensuring patients meeting ACS Field Triage criteria are transported to trauma centers, and activating trauma alerts prior to arrival. Together, these measures provide insight into how well EMS systems connect field care with hospital readiness.

**Trauma-04: Right Patient, Right Hospital**

**Definition:** Percentage of EMS transports originating from a 911 request for patients who meet ACS prehospital field triage criteria who are transported to a trauma center.

National data show that among more than 838,000 patients meeting triage criteria, only 26% of adults and 25.7% of pediatric patients were documented as transported to trauma centers. Yet when hospital capabilities are examined directly, more than 70% of patients were in fact taken to Level 1–3 trauma centers.

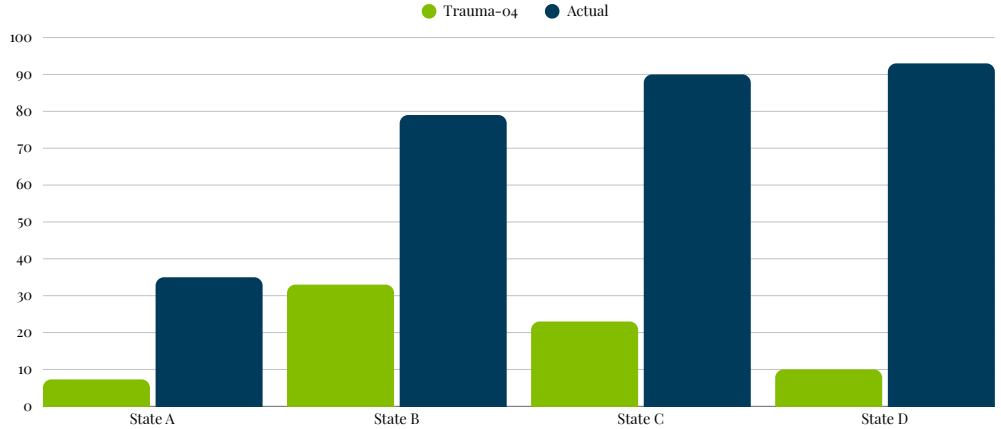
**Trauma-04 National Performance**

| | Numerator | Denominator | Performance |
|---|---|---|---|
| Adults | 201,754 | 774,826 | 26.0% |
| Pediatrics | 16,216 | 63,183 | 25.7% |

This discrepancy underscores a critical limitation: the measure's reliance on eDisposition.23, which requires providers to manually select hospital capabilities. Documentation errors or inconsistencies in this field mean that Trauma-04 often reflects documentation behavior rather than actual transport outcomes.

State-level data reinforce this gap. For example, North Carolina reports 33% performance using eDisposition.23, but when hospital capabilities are cross-referenced, 79% of patients were transported to trauma centers. Similar findings are emerging from Iowa, Connecticut, and other states.

Trauma-04: Documentation vs Actual Hospital Capability



# Trauma-04 &Trauma-14

## *Aligning documentation with reality to strengthen trauma system performance*

**Trauma-14: Activating the Trauma System Early**
**Definition:** Percentage of EMS transports originating from a 911 request for patients who meet ACS prehospital field triage criteria for whom a pre-arrival trauma alert or activation is initiated.

Nationally, performance remains low: 11% of adult patients and 11.4% of pediatric patients meeting triage criteria had a documented pre-arrival trauma alert. This measure highlights the importance of communication between EMS and hospital teams. Early activation primes trauma teams for rapid, coordinated care, yet documentation in eDisposition.24 remains persistently incomplete across agencies.

**Documentation Gaps and Systemic Barriers**
The variation between documented performance and actual hospital capability raises important questions:

- Does documentation accurately reflect reality?
- Are systemic barriers preventing providers from recording hospital designation and trauma alerts consistently?

The reliance on eDisposition.23 and eDisposition.24 conflates documentation compliance with clinical decision-making. Providers may make correct transport and activation decisions, but if documentation fields are incomplete or inaccurate, performance measures fail to capture true system effectiveness.

**Opportunities for Improvement**
To strengthen these measures and align them with patient-centered quality improvement, several strategies are recommended:

- Cross-validation of data: Link EMS records with authoritative hospital designation databases or state trauma registries to ensure accuracy.
- Improved documentation workflows: Explore ways to pre-populate hospital capability fields or streamline trauma alert documentation.
- Leadership accountability: Local, state, and national leaders should emphasize the importance of system-level solutions within the ePCR–or, when those are not feasible, the importance of accurate documentation–and provide appropriate training.
- Agency initiatives: Some EMS systems have piloted documentation prompts, automated data feeds, or feedback loops to improve compliance. Sharing these strategies can help others replicate success.

**Conclusion**
Trauma-04 and Trauma-14 highlight both the strengths and challenges of EMS trauma systems. While documented performance appears low, patients are in fact reaching trauma-capable hospitals at much higher rates. The persistent gap between documentation and reality underscores the need for refined measures, improved workflows, and stronger accountability. By focusing on accurate data capture and early system activation, EMS agencies can ensure that performance measurement reflects true patient outcomes–and that trauma care continues to advance in quality, safety, and effectiveness.

**Trauma-14 National Performance**

| | Numerator | Denominator | Performance |
|---|---|---|---|
| Adults | 85,471 | 774,826 | 11.0% |
| Pediatrics | 7,174 | 63,183 | 11.4% |

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# TBI-01

## *Fundamentals that Save Lives*

The Spider-Man series popularized the phrase, “With great power comes great responsibility.” The EPIC trial brought this idea into sharp focus for EMS, demonstrating its relevance to the care of patients with traumatic brain injury (TBI). Its findings highlighted the real-world impact of high-quality prehospital care on mortality in severe TBI—evidence that was both compelling and transformative for the field.

The EPIC trial evaluated the implementation of a clinical care bundle designed to prevent secondary brain injury in patients with moderate to severe TBI.[1] Building on research linking hypoxia, hypotension, and hyperventilation to worse outcomes, the care bundle focused on preventing these physiologic insults—or correcting them quickly when they occurred.

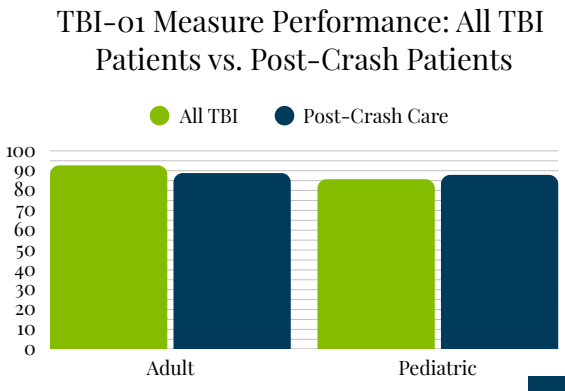
The bundle included four key actions for patients with moderate to severe TBI (defined as physical trauma with concern for brain injury, including those with GCS <15, confusion, multisystem trauma requiring intubation, or post-traumatic seizures):

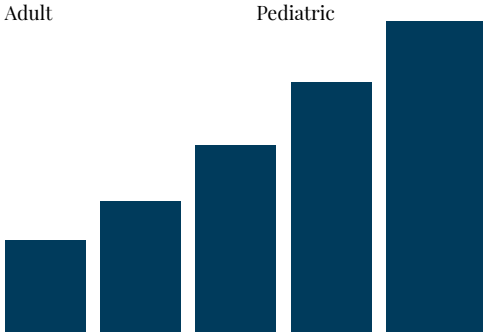
1. Continuous monitoring of oxygen saturation, blood pressure every 3–5 minutes, and continuous quantitative end-tidal $CO_2$ when an advanced airway is in place.
2. High-flow oxygen for all patients, with an escalating airway strategy for hypoxia or hypoventilation.
3. Fluid resuscitation for hypotension or evolving signs of shock.
4. Avoidance of hyperventilation, targeting an $ETCO_2$ of ~40 mmHg.

Pragmatic implementation had a dramatic impact. Among patients with severe TBI who received positive-pressure ventilation, the adjusted odds ratio for survival to hospital discharge was 3.52 (95% CI 1.96–6.34). Take a moment with that. No novel drug. No expensive device. Just the fundamentals of good care applied consistently over a brief prehospital period resulted in a profound improvement in meaningful, patient-centered outcomes.

**TBI-01 National performance**

| | Numerator | Denominator | Performance |
|---|---|---|---|
| Adults | 9,397 | 10,579 | 88.8% |
| Pediatrics | 1,135 | 1,291 | 87.9% |



# TBI-01

## *Fundamentals that Save Lives*

For EMS, the message is powerful: if vulnerable brain cells are lost during prehospital care, they cannot be regained. We have the power to do great good–and the responsibility to ensure we do no harm. This creates a ripe opportunity for meaningful prehospital quality measures.

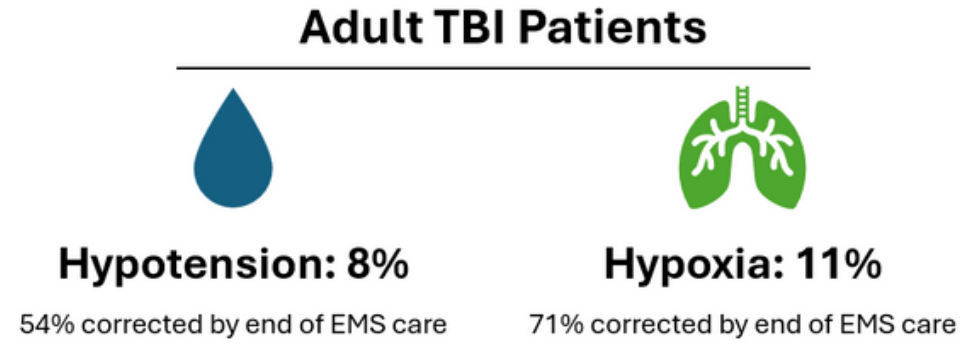
The NEMSQA TBI measures give us a first national glimpse at performance on one aspect of the EPIC care bundle: monitoring of oxygen saturation, blood pressure, and end-tidal $CO_2$. The end-tidal $CO_2$ component of the measure appropriately applies to all patients receiving assisted ventilations, recognizing this broader population is at risk for hyperventilation-associated secondary brain injury. Results are also disaggregated by circumstance (all TBI vs. post-crash care) and age (adults vs. pediatrics). Though not included as a formal measure, this report also examined the incidence of hypoxia and hypotension and whether these improved during EMS care.

A few key opportunities emerge. While overall vital-sign performance is strong, inequities remain between pediatric and adult patients–similar to what has been demonstrated in other studies.[2] There is also meaningful room to improve end-tidal $CO_2$ monitoring in all ventilated TBI patients, particularly those cared for following motor vehicle crashes, where performance is 55.6%. And while preventing hypoxia and hypotension is our primary goal, EMS plays a key role in managing them when they occur–yet hypoxia was reversed only about two-thirds of the time and hypotension in about half of cases.

**What next?**

- Examine your system's performance.
- Ask: Is this good enough given the documented impact on outcomes?
- Undertake improvement efforts using principles of improvement science that address system contributors.

**The opportunity is clear. The responsibility is ours.**



# Foundations First

## Elevating Trauma Care by Focusing on Basics that Save Lives

The 2025 National EMS Quality Alliance (NEMSQA) Annual Report centers on prehospital trauma quality. Rather than emphasizing rare, high-drama interventions, the report highlights the importance of system-level development, foundational patient safety practices, and seamless integration with hospital-based trauma systems. Evidence-based trauma measures provide EMS agencies, leaders, and clinicians with a reliable framework to ensure patients receive the best possible care in the field and across the broader trauma continuum.

**Back to the Basics: Vital Signs and Documentation**

A central theme of the report is the return to core EMS practices–taking and documenting vital signs. Measures such as Trauma 08 (GCS (motor), systolic blood pressure, respiratory rate, pulse rate, and pulse oximetry) and TBI 01 (oxygen level, ETCO2, and systolic blood pressure for suspected traumatic brain injury) highlight the critical role of thorough assessment. For TBI patients in particular, hypoxia and hypotension are deadly threats. The message is clear: measure, understand, act, and document. This disciplined approach reinforces the basics that keep trauma patients alive.

**Right Patient, Right Hospital**

Another key measure, Trauma 04, focuses on ensuring that patients who meet ACS trauma triage criteria are transported to designated trauma centers. This measure reflects the heart of a trauma system–matching patient injury severity with hospital resources. Errors in destination choice can lead to dangerous delays in definitive care. The report identifies a widespread challenge: EMS patient care records often fail to document hospital designation status. Addressing this gap requires leadership at every level–local, state, and national–to insist on accuracy and accountability.

**Activating the Trauma System Early**

Finally, Trauma 14 highlights the importance of initiating pre-arrival trauma alerts when ACS prehospital field triage criteria are met. Early activation primes hospital trauma teams, ensuring rapid, coordinated care upon patient arrival. This proactive step can make the difference between life and death, underscoring the value of communication and system readiness in trauma care.

**Conclusion**

Together, these measures form a core bundle of trauma quality indicators. They provide EMS systems with actionable insights into performance and reinforce the fundamentals of assessment, destination accuracy, and system activation. The 2025 NEMSQA Annual Report makes clear that excellence in trauma care begins with the basics–and that consistent documentation, accurate decisions, and timely alerts are the vital signs of quality.

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# Meet Our Team

## MICHAEL REDLENER
PRESIDENT

Michael Redlener, MD, FAEMS is an Emergency and EMS physician, Associate Professor at the Icahn School of Medicine, and Medical Director at Mount Sinai West. He serves on the NEMSQA board representing NAEMSP, where he previously chaired the Quality and Safety Committee and co-founded its Quality and Safety Course. His work centers on systems of care and evidence-based measures to improve trauma, disaster, cardiac, and stroke care.

## SHEREE MURPHY
EXECUTIVE DIRECTOR

Sheree is the Executive Director of NEMSQA, where she drives improvements in prehospital care through collaboration, standardized data, and measure development. She previously led the implementation of the American Heart Association's Mission Lifeline® for STEMI and Stroke with FDNY, helping launch New York City's EMS LVO stroke protocol and a regional quality dashboard. A Certified Professional in Health Care Quality and EMT, she has also consulted with the New York State Department of Health and continues to volunteer with a fire department rescue squad

## ALYSSA GREEN
DATA SCIENCE AND ANALYTICS STRATEGIST

Alyssa M. Green is the Data Science and Analytics Strategist at NEMSQA, a paramedic and Principal Data Enablement Strategist at ESO, specializing in data science and analytics to improve EMS workload, deployment, and systems of care. She has six years of 9-1-1 ambulance experience, three years as a volunteer EMT, and four years in clinical research. Alyssa joined NEMSQA in 2023 and holds a Master's in Applied Statistics, Data Analysis, and Data Science from the University of Kansas.

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# Meet Our Team

## MAIA DORSETT

MEASURE RESEARCH & ANALYSIS COMMITTEE CO-CHAIR

Maia Dorsett is an Emergency Medicine and EMS physician whose work focuses on advancing quality and education in prehospital care. She serves as the Associate Regional EMS Medical Director for Education & Quality in the Monroe-Livingston Region of New York, Medical Director for Gates Volunteer Ambulance, and Medical Director for EMS education programs at Monroe Community College. Nationally, she serves on the Boards of the National Association of EMS Physicians (NAEMSP) and the National Registry of EMTs (NREMT), and is Co-Chair of the NEMSQA Measure Analysis & Research Committee, where she helps lead national efforts to advance EMS quality measurement and improvement.

## MARSHALL WASHICK

MEASURE RESEARCH & ANALYSIS COMMITTEE CO-CHAIR

Marshall Washick serves as the Co-Chair of NEMSQA's Measure Analysis and Research Committee, where he helps guide the development, evaluation, and continuous refinement of national EMS quality measures. He brings deep experience in prehospital analytics, systems improvement, and data strategy, drawing on his leadership role at DC Fire and EMS and his broader work advancing evidence-informed EMS performance. Marshall's efforts focus on strengthening the scientific foundation of EMS measurement so agencies can better understand system behavior, improve patient outcomes, and drive meaningful change across the profession.

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# Meet Our Committees

## MEASURE ANALYSIS & RESEARCH

CHAIRS: DR. MAIA DORSETT & MARSHALL WASHICK

The Measure Analysis & Research Committee is dedicated to demonstrating how NEMSQA measures enhance patient care, clinical outcomes, and provider safety. Our work includes conducting retrospective research, developing NEMSQA measure reports, and providing analytical support for measure development and implementation. Current projects involve the airway measure report, evaluating non-transport assessments, and engaging with EMS data analysts through an R User group. Through these initiatives, we aim to build analytical capacity and drive improvements in EMS quality.

## MEASURE DEVELOPMENT

CHAIRS: DR. JEFF JARVIS & DR. BRYAN WILSON

The Measure Development Committee is responsible for creating, validating, and maintaining NEMSQA measures while upholding industry-standard measure development processes. Our work includes supporting the Florida Department of Health with a HRSA-funded rural EMS project, assisting the American College of Surgeons with the updated Field Triage Guidelines, and collaborating with NASEMSO on the prehospital airway EBG. Current projects focus on existing measure maintenance and developing new measures for post-crash care and sedation in agitation.

## MEASURE IMPLEMENTATION

CHAIRS: JULIUS MCADAMS & DR. TUNG-LIN "JESSE" YUAN

The Measure Implementation Committee enhances the adoption and accessibility of NEMSQA measures to support agency quality improvement efforts. Our current initiatives include raising awareness and providing implementation support through national, state, and regional EMS conferences, webinars with ProdigyEMS, ePCR vendor engagement, and resources such as measure office hours and the EMS Quality Improvement Partnership (EQuIP) collaboratives.

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# NEMSIS

The National Emergency Medical Services Information System Technical Assistance Center (NEMSIS TAC) 2024 Public-Release Research Dataset is the largest publicly available dataset of emergency medical service activations in the United States.

The 2024 Public-Release Research Dataset is a subset of the National EMS Database, a repository for EMS data collected from U.S. States and Territories. NEMSIS maintains the national standard for how patient care information, resulting from an emergency 911 call for medical assistance, is collected. The dataset includes 60,298,684 EMS activations submitted by 14,756 EMS agencies servicing 54 states and territories. Those interested in requesting a copy of the 2024 Public-Release Research Dataset can contact the NEMSIS TAC and fill out a request form at their website https://nemsis.org/using-ems-data/request-research-data. A link will be provided to the dataset, as well as the 2024 NEMSIS Data User Manual, NEMSIS Data Dictionary, Extended Data Definitions, and Sample SAS code.

## Limitations for our report:

1. While the majority of NEMSQA measures are built for national NEMSIS elements, there are some elements that are only available at the state level or are not required national elements.
2. De-duplication: multiple agencies may care for the same patient and submit separate patient care reports. Thus, NEMSIS is a registry of EMS activations, not patients. Care must be taken when interpreting the findings of NEMSQA measures.
3. Data lost due to move to NEMSIS from local level

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# Acknowledgements

This report represents the culmination of extensive work by the Measure Analysis and Research Committee, whose expertise and commitment have been instrumental in shaping this document especially the authors of the report:

Heidi Cordi
Kelly Burlison
Sheree Murphy
Bradley Cramer
Alyssa Green
Maia Dorsett
Michael Redlener

Thank you to our corporate sponsor and member organizations for their generous support and investment in EMS quality initiatives that have enabled the advancement of this important work.

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AIMHI Academy of International Mobile Healthcare Integration
National Registry of Emergency Medical Technicians

Thank you to our state partners commitment to continuous learning , testing and adoption of this important work.

## State Partners

Arkansas Department of Health
Connecticut Office of EMS
Delaware State Fire Commission
Florida Department of Health
Georgia Office of EMS and Trauma Region 9
Idaho Bureau of EMS
Iowa HHS-Bureau of Emergency Medical & Trauma Services
Kansas Board of EMS
Maine EMS
Maryland Institute for EMS Systems
Mississippi State Department of Health
New York State Department of Health
NJ Department of Health
North Carolina Office of EMS
Oregon EMS & Trauma Systems Program
Utah Dept of Public Safety Bureau of EMS
Vermont Department of Health

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Together, through the combined efforts of our members and corporate partners, we are making significant strides towards excellence in EMS quality. We look forward to the continued collaboration and progress that will drive positive change in the field of emergency medical services.

# Contact Us

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# References


1. Spaite DW, Bobrow BJ, Keim SM, et al.: Association of Statewide Implementation of the Prehospital Traumatic Brain Injury Treatment Guidelines With Patient Survival Following Traumatic Brain Injury: The Excellence in Prehospital Injury Care (EPIC) Study. JAMA Surg. 2019;July 17;154(7):e191152.

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