

Concept and Implementation Framework

The full concept paper: evidence base, framework, governance, and evaluation design for interagency active-threat medical readiness.

Mission

To help law enforcement, fire/rescue, EMS, dispatch, and hospital partners convert existing active-threat medical doctrine into shared, measurable, interagency readiness — through a bounded, independently evaluated pilot.

Theory of change

A shorter, better-coordinated interval between casualty contact and effective, protocol-consistent care depends on agencies that rarely train together being able to perform a rehearsed, measured sequence: agree on a shared crosswalk, train against it, exercise it jointly, measure the result, correct what fails, and replicate only where evidence supports it.

Principles

Additive, not substitutive. Locally governed. Observable. Bounded in cost. Falsifiable — designed so it can be shown not to work, and honest enough to report that if it happens.

Relationship to existing standards

Existing infrastructure	T-EMRP's non-duplicative contribution
TECC / TCCC	Operational crosswalk, local implementation, joint exercise, retention testing.
National EMS Education Standards	Active-threat competency mapping within local authorization and medical direction.
NIMS / ICS	Medical-readiness scenarios that test those principles under pressure.
NEMSIS	A limited readiness-data module or linked dataset; no replacement patient registry.
NEMSQA	Exercise- and training-focused measures crosswalked to existing quality concepts.
NEMSAC 2024 advisory	A bounded pilot that implements and evaluates selected recommendations.

Governance

Decision rights are distributed so no party — including the program itself — approves its own work. The program proponent holds no clinical approval right, no command authority, and no control over the evaluation or its findings. A U.S.-licensed medical director approves all clinical content.

Evaluation design

Prospective pre/post design with repeated measures, blinded or independent scoring where feasible, and a prespecified analysis plan. The independent evaluator controls the analysis and publishes positive, negative, and null findings. The primary endpoint is an observable readiness measure, such as time to effective hemorrhage control in a standardized scenario.

Limitations

T-EMRP has not demonstrated reliability across sites, persistence of training gains, cost-effectiveness, acceptability to U.S. agencies, or any effect on patient outcomes. These limitations are stated directly rather than left for a reviewer to discover.

T-EMRP is a proposed pilot framework in pre-pilot status. It does not replace TECC, TCCC, NIMS, state EMS rules, local protocols, or a physician medical director. Any certification issued during the pilot is a local completion record — not a license, and not a nationally recognized credential. Contact: gabriel.galvani@temrp.org