



Timothy Dienst

Position Sought: Mountain Region Director

Candidate Q&A

1. How would you describe your leadership style, and how has it influenced your work in EMS?

I'd call my leadership style collaborative, mission-driven, and determined. It starts with listening—to the clinicians doing the work, to the patients and communities we serve, and to the partners who see things differently than I do. I'm willing to make the hard calls, but I want those calls to be informed, transparent, and grounded in what's right for the people they affect.

Over the years I've learned to hold two things at once: a clear view of where EMS needs to go, and a realistic sense of what it actually takes to get there. A good idea isn't enough. Real change depends on relationships, careful planning, money that adds up, sound policy, and the persistence to keep pushing when progress is slow—which, in this profession, it usually is.

That's the mindset behind the work I've championed: mobile integrated healthcare, behavioral health response, treatment in place, and other models that meet patients where they are. It's also behind my advocacy for sustainable reimbursement, workforce development, and for rural, frontier, and Tribal EMS—and for finally getting EMS recognized as the essential healthcare and public safety service it already is in practice.

I also believe a leader's job is to make room for other people to succeed. I've worked to develop the next generation of leaders, to invite clinicians to bring their ideas forward, and to build partnerships that cross organizational and geographic lines. No single delivery model, agency, or person has all the answers. We're strongest when governmental, nonprofit, private, hospital-based, fire-based, volunteer, urban, rural, and Tribal services all have a real voice and pull in the same direction.

If there's one thing four decades in this field has taught me, it's that advocacy and patient care are the same job. The decisions we make about reimbursement, legislation, education, and workforce support are what ultimately determine whether an ambulance shows up, whether the clinician on board is ready and supported, and whether the patient gets the care they need.

That's what keeps me focused—our members, our profession, our communities, and the patients counting on us. Leadership isn't a title. It's taking responsibility, bringing people together, and turning a shared vision into something that lasts.

2. In what ways do you advocate for EMS? What strategies would you recommend for NAEMT to strengthen its advocacy efforts and gain recognition for EMS as an essential service?

I advocate for EMS by connecting what actually happens on a call to the policy, funding, and regulatory decisions that decide whether our systems survive. I've done that at the local, state, and national levels—building relationships with elected officials and community members, testifying on legislation, drafting policy, working through EMS coalitions, and helping other leaders and clinicians tell their own stories in a way decision-makers hear.

The issues I've pushed hardest on are sustainable Medicare, Medicaid, and commercial reimbursement; treatment in place and alternative destinations; mobile integrated healthcare and behavioral health response; rural, frontier, and Tribal EMS; workforce development; and the simple, common-sense idea that we should be paid for readiness, not just for transporting a patient. Through all of it, I try to keep every delivery model at the table and patients at the center.

Here's the hard truth: EMS performs an essential function every day, but in most states—and nationally—we've never actually been established or recognized as an essential service. NAEMT is the right organization to change that, and to turn recognition into law, policy, and dependable funding rather than a nice-sounding label.

A few things would move us forward. We need one clear, consistent message that explains EMS as far more than a ride—readiness, mobile integrated healthcare, behavioral health, disaster response, community resilience—in language anyone can follow. We need to put real tools in the hands of state associations and local leaders: model legislation, economic-impact data, talking points, and practical guidance for working with policymakers. We need to widen our coalitions to include hospitals, behavioral and rural health providers, emergency management, the fire service, Tribal leaders, patient advocates, and even payers, because they all have a stake in this. And we need to finally quantify what readiness costs—what it takes to keep people, ambulances, equipment, communications, and medical oversight ready around the clock, even when no one is transported.

Above all, NAEMT has to keep its members engaged—with training, timely action alerts, direct congressional contact, and chances for clinicians to speak from experience. Nothing moves a legislator like a paramedic from their own district.

Recognition can't just be symbolic. It has to lead to reliable funding, fair reimbursement, real workforce investment, and a genuine seat for EMS at the healthcare, public safety, and emergency-preparedness tables.

3. How can NAEMT better support and develop the EMS workforce, considering generational differences? How would you convey the value of membership to both current and prospective members?

We support the workforce best when we treat generational differences as real without turning them into stereotypes. Clinicians at different stages of their careers do communicate, learn, and measure success a little differently. But underneath that, almost everyone wants the same things: meaningful work, fair pay, respect, good leadership, room to grow, and the ability to take great care of patients.

NAEMT's job is to help agencies build workplaces where those things are actually possible. That means practical resources on recruitment, onboarding, mentorship, engagement, psychological and physical safety, mental health, scheduling, and retention. I'd put special emphasis on developing supervisors and new leaders, because in my experience an employee's relationship with their leadership is usually what decides whether they stay in EMS or walk away.

Education has to be flexible and easy to reach—strong in-person offerings alongside online, on-demand, and interactive learning. And we should be honest that the career ladder is no longer just EMT to paramedic. There's a real future in education, leadership, mobile integrated healthcare, behavioral health, quality improvement, preparedness, research, and advocacy, and we should show people those paths.

I'm also a believer in mentorship that runs both directions. Our veterans carry judgment and institutional memory we can't afford to lose. Our newer clinicians bring fresh perspective, comfort with technology, and expectations that push us to get better. Each has something to teach the other.

As for the value of membership, we have to show—not just say—that it makes a difference at every stage of a career. Members should regularly see how their dues translate into national advocacy, quality education, resources, leadership opportunities, and a louder voice for EMS.

For someone deciding whether to join, the honest question is “How does this help me?” A new EMT may want education, connection, and guidance. A mid-career clinician may want leadership development and new opportunities. A seasoned leader may want to help shape where the profession is headed. We should have a good answer for all three.

The way to get that across isn't a discount list—it's authentic member stories, peer ambassadors, partnerships with state associations and training programs, and showing up directly at agencies. Membership should feel less like a transaction and more like an invitation to belong, grow, contribute, and be heard.

In the end, NAEMT's real value is turning thousands of individual clinicians into one national voice.

4. What is a pressing issue currently facing EMS, and how could NAEMT help address it?

To me the most pressing issue is long-term sustainability. Our communities expect us to be there every hour of every day, but we're still funded mostly by a model that pays for the transport and all but ignores the readiness, assessment, and treatment that are the real work.

Every agency has to keep trained clinicians, ambulances, equipment, communications, medical oversight, and facilities ready before a single call ever comes in. A large share of that cost is fixed: whether a unit runs two calls in a day or twenty, it still has to be staffed and equipped around the clock. Each call does add variable cost—supplies, fuel, vehicle wear, crew time—but the core cost of simply being ready doesn't shrink when volume is low, and none of it goes away when a patient isn't transported. That's exactly why the math is hardest for rural, frontier, Tribal, volunteer, and low-volume services: they spread those fixed readiness costs across far fewer transports, so their cost per transport runs much higher than a busy urban system's. No delivery model is immune, but the thin-volume services feel it first.

That financial pressure feeds straight into our workforce shortage. You can't recruit and keep good clinicians without competitive pay, safe conditions, solid leadership, quality education, and a path forward. When reimbursement doesn't cover the true cost of being ready, agencies are forced into decisions that hurt their people, their capacity, and eventually their patients.

NAEMT can lead here by driving a coordinated national push for real payment reform—permanent reimbursement for treatment in place, Mobile Integrated Health, telehealth-supported care, and transport to appropriate alternative destinations, along with payment that actually accounts for readiness and the higher cost of serving rural and isolated communities.

Part of that is data. We need a standardized national way to measure what readiness costs and what EMS is worth—unit-hour costs, geographic coverage, response capacity, uncompensated care, community preparedness, and the downstream healthcare costs we prevent. Not just runs and transports. Reliable numbers are what will finally convince Congress, federal agencies, states, and payers that you can't fund EMS on transportation fees alone.

NAEMT should also unite the profession around a shared set of reform principles and build the coalitions to back them—state associations, national partners, hospitals, rural health advocates, Tribal leaders, patient groups, and policymakers. And it has to keep members in the fight with clear talking points, action alerts, local data, and real chances to tell decision-makers what they see every day.

This all comes back to recognition. EMS performs an essential healthcare and public safety function, but that role still isn't written into law or backed by dependable funding across most of the country. Closing that gap is the work—and it should bring with it sustainable funding, fair reimbursement, workforce investment, and a permanent place for EMS in healthcare, public safety, and emergency preparedness policy.