



Justin Duncan

Position Sought: Great Plains Region Director

Candidate Q&A

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

I would describe my leadership style as vision-driven, collaborative, and intentionally disruptive. I believe a leader's responsibility is not simply to manage what exists today, but to challenge the organization, and sometimes the profession, to think about what needs to exist tomorrow.

Throughout my career in EMS, I have tried to surround myself with talented people, give them ownership, and create an environment where it is acceptable to challenge traditional thinking. I am comfortable asking, "Why do we do it this way?" and, more importantly, "Is there a better way?" That mindset has influenced much of my work around mobile integrated healthcare, rural health transformation, regionalization, workforce development, and EMS payment reform.

At the same time, I believe strongly that leadership is about relationships. Meaningful change in EMS cannot happen in isolation. It requires bringing together frontline clinicians, EMS agencies, hospitals, health centers, health plans, policymakers, and community partners, often organizations that historically have not viewed themselves as part of the same system.

Ultimately, my leadership philosophy is centered on moving EMS beyond being viewed solely as an emergency transportation service and toward becoming a fully integrated part of the healthcare system. That requires us to be willing to evolve, measure outcomes, demonstrate our value, and sometimes challenge our own identity as a profession.

I am willing to push the boundaries, but I also recognize that lasting transformation only happens when you bring people with you.

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 ensuring our profession has a voice in the rooms where decisions about healthcare policy, reimbursement, rural health, and system transformation are being made. For me, advocacy is not an annual trip to the Capitol, it is an ongoing effort to build relationships, educate decision-makers, develop coalitions, and demonstrate the value EMS brings to healthcare.

As **President of the Missouri EMS Association**, I work with state leaders, policymakers, healthcare organizations, and EMS agencies on workforce, reimbursement, rural EMS sustainability, MIH-CP, regionalization, and healthcare integration. Nationally, as **Chair of the NAEMT Economics Committee and a member of the NAEMT Advocacy Committee**, I have participated in Congressional advocacy focused on Medicare and Medicaid payment reform, sustainable reimbursement, and recognition of EMS for the healthcare we provide, not simply the transportation we perform.

Through my involvement with the **National Rural Health Association**, I have also worked to bring EMS into broader rural healthcare policy discussions. Most recently, I have been deeply involved in Missouri's **Rural Health Transformation Program**, advocating for EMS and MIH-CP to be included in healthcare transformation and then helping translate that advocacy into implementation. I also work directly with Medicaid managed care organizations and other health plans to demonstrate how EMS and MIH-CP can improve outcomes, close care gaps, reduce unnecessary utilization, and create measurable value.

These experiences have reinforced one of my strongest beliefs: **EMS cannot advocate only to EMS.**

For NAEMT, I believe our advocacy should focus on recognition of EMS as an **essential healthcare service**, sustainable payment reform, recognition of EMS clinicians as healthcare professionals, and full integration of EMS into the healthcare system.

We must also tell our story differently. Saying EMS is essential is not enough. We need to bring **data, outcomes, and economics** that demonstrate both the consequences of underfunding EMS and the value created through emergency response, MIH-CP, treatment in place, alternate destinations, care coordination, and prevention.

NAEMT should also intentionally build coalitions beyond traditional EMS organizations. Our case becomes much stronger when hospitals, FQHCs and RHCs, physicians, rural health organizations, health plans, patient advocates, and community leaders are standing beside us telling policymakers that EMS is essential to their ability to care for patients.

Finally, we need a coordinated grassroots strategy that equips EMS professionals to advocate effectively in their own communities and congressional districts.

Our message should be simple: **EMS is not simply a ride to the hospital. We are healthcare.** We are an essential part of America's healthcare infrastructure, and our advocacy must demonstrate the clinical, operational, and economic value of investing in EMS.

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?

The EMS workforce has changed, and our approach to supporting it must change as well. I do not believe younger generations are less committed to EMS; I believe they are asking different questions of their profession and their employers. They want to know: **Will I be valued? Can I grow? Can I have a sustainable career and still have a life? Does my work have purpose, and will my voice matter?**

NAEMT can help the profession answer those questions.

We must recognize that a one-size-fits-all workforce strategy will not work across multiple generations. More experienced clinicians bring institutional knowledge, mentorship, and professional experience that we cannot afford to lose. Newer generations bring different expectations around technology, communication, flexibility, professional development, mental wellness, and work-life integration. Rather than viewing those differences as a conflict, NAEMT should help EMS organizations leverage them.

I would prioritize **leadership development, mentorship, career pathways, and professional identity**. We need intentional opportunities to connect emerging EMS professionals with experienced leaders, while also creating meaningful opportunities for younger clinicians to lead. Leadership development cannot begin when someone becomes a chief; we should identify and develop leaders much earlier in their careers.

We also need to demonstrate that EMS can be a **career, not simply a job or a steppingstone**. That means continuing to advocate for appropriate compensation, sustainable reimbursement, education, clinician recognition, expanded career pathways, and opportunities in MIH-CP, education, leadership, quality, research, policy, and other areas of healthcare.

The same principle applies to membership. We cannot simply tell someone, **“You should join NAEMT because you work in EMS.”** We have to demonstrate why membership matters to them.

For an experienced EMS professional, that value may be advocacy, continuing education, leadership opportunities, professional networking, or the ability to influence the future of the profession. For an early-career EMT or paramedic, it may be mentorship, education, career development, connection with peers, and discovering opportunities they did not know existed.

Most importantly, members need to see what NAEMT is doing **for them and because of them**. When NAEMT advocates on Capitol Hill, advances payment reform, develops education, influences national policy, or creates opportunities for EMS clinicians, we should connect those accomplishments directly back to membership.

I would ask NAEMT to make a specific commitment: **create a defined pathway that takes an EMT or paramedic from new member, to engaged member, to emerging leader, to national leader**. Pair early-career members with mentors, give them meaningful opportunities to serve, intentionally develop their leadership skills, and create a seat for them at the table before they have a title.

If we can show an EMS professional, at any stage of their career, **“There is a place for you here, there is a pathway for you here, and your voice can help shape this profession,”** we will do more than grow membership. We will develop the next generation of EMS leaders and give them a reason to stay.

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

I believe one of the most pressing issues facing EMS is an **identity crisis**.

For decades, we have defined ourselves primarily by emergency response and transportation. Those functions remain critically important, but the healthcare system around us is changing. Healthcare is increasingly focused on outcomes, quality, access, prevention, care coordination, population health, and value. EMS has an opportunity to become an integral part of that ecosystem, but simply asking for a seat at the table is not enough.

If we want to be part of the healthcare ecosystem, we need to act like it.

That means thinking beyond the transport. We need to understand quality measures, document in ways that demonstrate clinical outcomes, exchange data with healthcare partners, close care gaps, participate in care coordination, understand value-based payment models, and measure the impact of the care we provide.

It also means examining our professional identity. Are we transportation providers who happen to deliver healthcare, or are we healthcare professionals who provide care wherever the patient needs us?

I believe the future requires the latter.

Through my work in rural health transformation and MIH-CP, I have seen what happens when EMS begins operating as part of a broader healthcare team. Community paramedics can help manage chronic disease, close HEDIS and other quality gaps, address barriers to care, connect patients with

primary care, reduce unnecessary utilization, and provide meaningful clinical information back to healthcare partners. Traditional EMS can also play a much larger role through treatment in place, alternate destinations, navigation, and better integration with the patient's longitudinal care.

But we cannot expect healthcare to recognize our value if **we are not measuring it, documenting it, and communicating it in the language healthcare understands.**

NAEMT can help lead this professional evolution.

I would ask NAEMT to develop a **national strategy for EMS healthcare integration** that gives agencies and clinicians practical tools to make this transition. That should include education on healthcare quality and value-based care, standardized outcome measures, better clinical documentation, interoperability, MIH-CP, alternate care models, and resources that help EMS leaders build meaningful partnerships with hospitals, FQHCs, RHCs, health plans, and other healthcare organizations.

At the same time, NAEMT should continue advocating for reimbursement and policy changes that recognize this expanded role. We cannot transform the clinical model without transforming the financial model.

The question facing our profession is bigger than what EMS will do next. It is **what EMS wants to become.**

We can continue to define ourselves by where we take the patient, or we can define ourselves by the value we bring to the patient and the healthcare system.

If we want to be healthcare, we have to act like healthcare, document like healthcare, measure like healthcare, integrate like healthcare, and ultimately be accountable for outcomes like healthcare.