CoAEMSP Interpretations of the CAAHEP Standards and Guidelines

For the Accreditation of Educational Programs in the EMS Professions

This companion document contains the CAAHEP ***Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions*** with CoAEMSP interpretations adopted by CoAEMSP through policies. The interpretations are NOT part of the *Standards and Guidelines* document and are subject to change by CoAEMSP. Policy revisions may occur often, so this document should be reviewed frequently to ensure the most current version. Please refer to the Glossary for the definition of terms which is available at www.coaemsp.org/standards. Questions regarding the interpretations can be directed to the CoAEMSP Executive Office.

	CoAEMSP Interpretations
Standard interpretations first approved by CoAEMSP August 2010; revisions February 2011, August 2011, August 2012, February 2013, February 2014, August 2014, August 2015, February 2016	CoAEMSP interpretations are developed through Committee policy. Those policies are subject to change.
I. Sponsorship **A. Sponsoring Institution** A sponsoring institution must be at least one of the following:	**A. Sponsoring Institution** A sponsoring institution must be at least one of the following, and **must either award credit for the program or have an articulation agreement with an accredited post-secondary institution:**
1. A post-secondary academic institution accredited by an institutional accrediting agency or equivalent that is recognized by the U.S. Department of Education, and must be authorized under applicable law or other acceptable authority to provide a post-secondary program or to approve college credit, which awards a minimum of a certificate at the completion of the program.	1. This is a college, university, community college, junior college that is accredited by a regional or national institutional accrediting body. Vocational schools, proprietary schools, and religious schools may be accredited by regional accrediting agencies or specialized institutional accrediting bodies. A list of approved accrediting organizations can be found on the US Department of Education web site. If academic credits are not granted during the program offered in the accredited academic institution (e.g., the program is offered through continuing education), there must be an articulation agreement for those who complete the program. For each state in which the program has enrolled students, the program must document that it has successfully notified the State EMS office that the program has students in that state.
2. A foreign post-secondary academic institution acceptable to CAAHEP.	2. This will be determined on a case-by-case basis.
3. A hospital, clinic or medical center accredited by a healthcare accrediting agency or equivalent that is recognized by the U.S. Department of Health and Human Services, and authorized under applicable law or other acceptable authority to provide healthcare, which is affiliated with an accredited post-secondary educational institution or equivalent or an accredited graduate medical education program, which awards a minimum of a certificate at the completion of the program.	3. A hospital, clinic, or medical center may be a sponsor under certain conditions. The hospital, clinic, or medical center must maintain permanent records, must insure quality of the program, and must assure that all fair practices are followed. A hospital, clinic, or medical center, may be a sponsor under # 3: • It must be accredited by The Joint Commission or its equivalent, and authorized by the State to provide health care • It must have an articulation agreement with an accredited educational institution (Standard I.A.1) that can provide college credits for the training

	An **articulation agreement** is an agreement between an educational institution and a training facility to provide college credit to individuals completing the training program. This agreement allows students to receive college credit if they enroll at the educational institution; it does not require that students who do not register receive college credit. The articulation agreement may be composed as a memorandum of understanding, transfer agreement, or other suitable instrument, as long as the requirements of articulation are met.
4. A branch of the U.S. Armed Forces or other governmental educational or medical service, which is affiliated with an accredited post-secondary educational institution or equivalent that is authorized under applicable law or other acceptable authority to provide a post-secondary educational program which awards a minimum of a certificate at the completion of the program, or a national organization authorized under applicable law or other acceptable authority to approve college credit.	4. A governmental fire academy or EMS training agency may be a sponsor under #4 – It must be an agency of the federal, state, city, or county government – It must be authorized by the State to provide initial educational programs – It must - - EITHER - - have an articulation agreement with an educational institution (Standard I.A1) that can provide college credits for the training, if it cannot give credits in its own rights - - OR - - be recognized by the state as a post-secondary educational institution
B. Consortium Sponsor 1. A consortium sponsor is an entity consisting of two or more members that exists for the purpose of operating an educational program. In such instances, at least one of the members of the consortium must meet the requirements of a sponsoring educational institution as described in I, A.	
2. The responsibilities of each member of the consortium must be clearly documented as a formal affiliation agreement or memorandum of understanding, which includes governance and lines of authority.	2. A consortium agreement is an agreement, contract, or memorandum of understanding between two entities to provide governance of a program. The members of the consortium set up a separate Board to establish and run an educational program. The governance, lines of authority, roles of each partner must be established in the agreement, and have an organizational chart.
C. Responsibilities of Sponsor The Sponsor must assure that the provisions of these **Standards** are met.	

II. Program Goals

A. Program Goals and Outcomes

There must be a written statement of the program's goals and learning domains consistent with and responsive to the demonstrated needs and expectations of the various communities of interest served by the educational program. The communities of interest that are served by the program include, but are not limited to, students, graduates, faculty, sponsor administration, hospital/clinic representatives, physicians, employers, police and fire services, key governmental officials, the public, and nationally accepted standards for roles and functions.

Program-specific statements of goals and learning domains provide the basis for program planning, implementation, and evaluation. Such goals and learning domains must be compatible with both the mission of the sponsoring institution(s) and the expectations of the communities of interest. Goals and learning domains are based upon the substantiated needs of health care providers and employers, and the educational needs of the students served by the educational program.

The minimum goal is listed under II.C below. This is a required goal.

The program can have any additional goals that it wishes, but those goals must be measurable and the program must evaluate the goal(s) and have the Advisory Committee assist in formulating and revising the goal(s) at least annually.

B. Appropriateness of Goals and Learning Domains

The program must regularly assess its goals and learning domains. Program personnel must identify and respond to changes in the needs and/or expectations of its communities of interest.

An advisory committee, which is representative of these communities of interest, must be designated and charged with the responsibility of meeting at least annually, to assist program and sponsor personnel in formulating and periodically revising appropriate goals and earning domains, monitoring needs and expectations, and ensuring program responsiveness to change.

Hospital/clinic representatives should include supervisory and administrative personnel to whom the students or graduates deliver their patients and who provide training sites for students;

Physician representatives should include the emergency physicians to whom students and/or graduates deliver their patients as well as trauma surgeons, internists, cardiologists, pediatricians, and family physicians;

Employer representatives should include employers of the program graduates and the ambulance supervisory personnel and administrative personnel where the students perform internships;

B. The Advisory Committee must meet at least once a year and review the goals, outcomes for the classes in the last year and make recommendations to the program.

The Advisory Committee meetings should also include review of all minimum competency requirements, including team leads, achievement of goals, analysis of the goals, action plan, and results of action where appropriate and review of the annual report and other objective data that supports program evaluation.

There must be an Advisory Committee roster indicating the communities of interest that the members represent.

Police and fire services would be represented, if they have a role in EMS in the community served by the program.

A key governmental official, where appropriate, could include an elected official, an appointed public official, an individual involved in emergency management, or other public official.

The public member of the Advisory Committee should be a person who has valuable input to the program. The public member should not be employed by the sponsor or a clinical affiliate and should not qualify as any other named community of interest representative.

The Advisory Committee meetings must have Minutes reflecting the attendees, and meaningful discussion and actions during the meeting.

Key governmental official representatives should include state and/or regional training coordinators/field representatives.

C. Minimum Expectations

The program must have the following goal(s) defining minimum expectations:

- Emergency Medical Technician-Paramedic

  "To prepare competent entry-level Emergency Medical Technician-Paramedics in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains," with or without exit points at the Emergency Medical Technician-Intermediate, and/or Emergency Medical Technician-Basic, and/or First Responder levels.

- Emergency Medical Technician-Intermediate

  "To prepare competent entry-level Emergency Medical Technician-Intermediates in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains," with or without exit points at the Emergency Medical Technician-Basic and/or First Responder levels.

Programs adopting educational goals beyond entry-level competence must clearly delineate this intent and provide evidence that all students have achieved the basic competencies prior to entry into the field.

Programs not offering Associate's or Bachelor's degrees are encouraged to establish articulation agreements that provide for maximum transfer of clinical and clinical related coursework. Coursework in general education, social sciences, and health sciences should parallel coursework offered in colleges and universities.

III. Resources

A. Type and Amount

1. Program Resources

Program resources must be sufficient to ensure the achievement of the program's goals and outcomes. Resources include, but are not limited to: faculty, clerical/support staff, curriculum, finances, classroom/laboratory facilities, ancillary student facilities, hospital/clinical affiliations, field/internship affiliations, equipment/supplies, computer resources, instructional reference materials, and faculty/staff continuing education.

For most programs, there should be a full-time clerical position that reports to the program director.

Instructional aids may include clinical specimens, documents and related materials, reference materials, equipment, and demonstration aids

1. There are no set numbers for resources; only the requirement that the resources are sufficient as documented by the on-going Resource Assessment system (see Standard III.D) and other objective data.

The same space can be used for class and lab provided the space is adequate for the number of students and accommodate the required activity.

While a full-time clerical position might be ideal, the comparable amount of support can be provided by a combination of resources, such as part-time positions, clerical sharing, work study students. However, the sufficiency of the clerical support is objectively determined by the data collected for resource assessment.

The objective measurement is reflected by the adequacy of program activities such as: timely filing of documents, phone coverage, organized records, up to date files, adequate correspondence turnaround time, **regardless of the means by which the program accomplishes those tasks**.

2. Hospital/Clinical Affiliations and Field/Internship Affiliations

For all affiliations students shall have access to adequate numbers of patients, proportionally distributed by illness, injury, gender, age, and common problems encountered in the delivery of emergency care appropriate to the level of the Emergency Medical Services Profession(s) for which training is being offered.

Hospital/clinical experiences of the program should include the operating room, recovery room, intensive care unit, coronary care unit, labor and delivery room, pediatrics, and emergency department, and include exposure to an adequate number of pediatric, obstetric, psychiatric, and geriatric patients.

2. The clinical resources must ensure exposure to, and assessment and management of the following patients and conditions: adult trauma and medical emergencies; airway management to include endotracheal intubation; obstetrics to include obstetric patients with delivery and neonatal assessment and care; pediatric trauma and medical emergencies including assessment and management; and geriatric trauma and medical emergencies.

The program must set and require minimum numbers of patient contacts for each listed category. **Those minimum numbers must be approved by the Medical Director and endorsed by the Advisory Committee with documentation of those actions.** The tracking documentation must then show those minimums and that **each** student has met them. There must be periodic evaluation that the established minimums are adequate to achieve competency. **No minimum number can be fewer than two (2), including each pediatric age subgroup.**

The objectives must clearly state the intent of the rotation and outcomes required. While the specific units/rooms may provide the types of patients to meet the objectives, there are likely other locations and creative activities that can provide the necessary type of patient encounters.

The access and availability of the patients is the critical issue. The location of the experiences is at the discretion of the program. For example, psychiatric patient exposures may occur in the emergency department.

Live patient encounters must occur; however, appropriate simulations can be integrated into the educational process to provide skills acquisition, develop skills proficiency, provide practice opportunities for low volume procedures, and ensure competency prior to exposure to a patient. The program must show that this

	method of instruction is contributing to the attainment of the program's goals and outcomes. **For airway management**: Each student must demonstrate competency in airway management. The program sets the required minimums approved by the Medical Director and Advisory Committee as described above. For example, the paramedic student should be successful in a combination of live intubations, high definition simulations, low fidelity simulations, and cadaver labs in all age brackets. High definition simulation is highly recommended but optional. Low fidelity simulation is defined by traditional simulation heads. Paramedic students should have exposure to diverse environments, including but not limited to hospital units (e.g., operating rooms, emergency departments, intensive care units), ambulatory centers, and out of hospital settings (e.g., ambulance, field, home) and laboratories (floor, varied noise levels, varied lighting conditions). The paramedic student should have no fewer than fifty (50) attempts at airway management across all age levels, with a 90% success rate utilizing endotracheal intubation models in their last ten (10) attempts. The paramedic student needs to be 100% successful in the management of their last twenty (20) attempts at airway management. The majority of airway attempts should be emphasized with live intubations, realistic simulation labs, or both. As with all other required skills, terminal competency needs to be validated by the program medical director's signature. Evaluation of the clinical and field internship sites should be done by the program. They should ensure, through tracking (Standard III.C.2) that the clinical and field internship sites provide the minimum requirements for competency (See II.C and IV.A.1).
B. Personnel The sponsor must appoint sufficient faculty and staff with the necessary qualifications to perform the functions identified in documented job descriptions and to achieve the program's stated goals and outcomes. 1. **Program Director** a. Responsibilities The program director must be responsible for all aspects of the program, including, but not limited to: 1) the administration, organization, and supervision of the educational program,	1) As part of the administration, organization, and supervision of the program, the Program Director must ensure that there is preceptor orientation/training. The training/orientation must include the following topics: • Purposes of the student rotation (minimum competencies, skills, and behaviors) • Evaluation tools used by the program • Criteria of evaluation for grading students • Contact information for the program

2) the continuous quality review and improvement of the educational program, 3) long range planning and ongoing development of the program, 4) the effectiveness of the program and have systems in place to demonstrate the effectiveness of the program, 5) cooperative involvement with the medical director, 6) adequate controls to assure the quality of the delegated responsibilities. b. Qualifications	• Program's definition of Team Lead • Program's required minimum number of Team Leads • Coaching and mentorship techniques The training media may take many forms: written documents, formal course, power point presentation, video, on-line, or there could be designated trainers on-site that the program relies on. The program should tailor the method of delivery to the type of rotation (e.g. hospital, physician office, field). The program must demonstrate that **each field internship preceptor** has completed the training. For example, there may be an on-line session documenting completion by the preceptor, or there may be a written packet provided by the program, which is read and signed by the preceptor at the start of the rotation, or a representative of the program may meet briefly with the potential preceptors at that location. For field internship experiences, the program should focus on the evaluation of the experience, but that evaluation must include an evaluation of **each** active field internship preceptor. The program must identify a key person in hospitals (departments), in other clinical experience settings, and for field experience. The program must demonstrate that every key person has completed the orientation. The program can then arrange to have those key personnel provide guidance to any other preceptors in those settings. For clinical and field experiences, the program should focus on the evaluation of the experience, but that evaluation must include at least an overall, not necessarily individual, evaluation of the preceptors. The program must provide evidence of the completion of the training of field internship preceptors by dated rosters of participants, on-line logs, signed acknowledgement by the field internship preceptor.

The program director must:

1) possess a minimum of an Associate's degree for Emergency Medical Technician-Intermediate and a minimum of a Bachelor's degree for Emergency Medical Technician-Paramedic from a regionally accredited institution of higher education,

The program director should possess a Bachelor's degree or higher for Emergency Medical Technician-Intermediate and a Master's degree or higher degree for Emergency Medical Technician-Paramedic from a regionally accredited institution of higher education.

2) have appropriate medical or allied health education, training, and experience,

3) be knowledgeable about methods of instruction, testing and evaluation of students,

4) have field experience in the delivery of out-of-hospital emergency care,

5) have academic training and preparation related to emergency medical services at least equivalent to that of program graduates,

The program director should be currently certified in the United States to practice out-of-hospital care and currently certified by a nationally recognized certifying organization at an equal or higher level of professional training than that for which training is being offered.

6) be knowledgeable concerning current national curricula, national accreditation, national registration, and the requirements for state certification or licensure.

1) The Bachelor's degree must be awarded by an academic institution that is accredited by an institutional accrediting agency that is recognized by the United States Department of Education (USDE). The Bachelor's degree may be in any major. (02/05/2011)

2. **Medical Director**

a. Responsibilities

The medical director must be responsible for all medical aspects of the program, including but not limited to:

2. There must be written documentation that the Medical Director fulfills each of the responsibilities:

1) review and approval of the educational content of the program curriculum to certify its ongoing appropriateness and medical accuracy,	1) Documentation could include a signed memorandum stating the nature of review activities, dates conducted, etc.
2) review and approval of the quality of medical instruction, supervision, and evaluation of the students in all areas of the program,	2) Documentation could include a signed memorandum stating the nature of review activities, date of review, etc. This responsibility does not mean that the Medical Director must be present for each type of activity – only that he/she reviews and approves. Review of evaluations is for those that relate to the students, not the faculty/staff. The Medical Director is not responsible for evaluation of program personnel. There must be evidence of interaction between the Medical Director and the students.
3) review and approval of the progress of each student throughout the program and assist in the development of appropriate corrective measures when a student does not show adequate progress,	3) Documentation could include descriptions of on-going activities, date(s) of communication with program director for such activities, etc.
4) assurance of the competence of each graduate of the program in the cognitive, psychomotor, and affective domains,	4) Documentation must include a terminal competency form for each graduate signed and dated by the Medical Director); [A CoAEMSP Terminal Competency form is available on the CoAEMSP web site for use by the program, if so desired.] At the conclusion of the program there must be a document signed by the Medical Director attesting to the competence of each graduate as an entry-level Paramedic. A terminal competency form for each student must contain a dated original signature by the medical director. A stamped signature is not acceptable. A secure electronic signature is acceptable. A secure electronic signature is **not** a jpeg or other type of image attached to a document. A secure electronic signature is unique and under the sole control of the individual making the signature, the technology used must be able to identify the person making the signature, and the technology must be able to identify if the document was changed in any way after the electronic signature was applied.
5) responsibility for cooperative involvement with the program director,	
6) adequate controls to assure the quality of the delegated responsibilities. *For most programs, the medical director should commit a significant amount of time to the program, for which appropriate compensation is often necessary.*	6) The Medical Director maintains final responsibility for items 1 thru 5.

b. Qualifications

The medical director must:

1) be a physician currently licensed to practice medicine within the United States and currently authorized to practice within the geographic area served by the program, with experience and current knowledge of emergency care of acutely ill and injured patients,

2) have adequate training or experience in the delivery of out-of-hospital emergency care, including the proper care and transport of patients, medical direction, and quality improvement in out-of-hospital care,

3) be an active member of the local medical community and participate in professional activities related to out-of-hospital care,

4) be knowledgeable about the education of the Emergency Medical Services Professions, including professional, legislative and regulatory issues regarding the education of the Emergency Medical Services Professions.

1) The program must have a formal relationship with a physician currently authorized to practice in each state where the program's students are participating in patient care, to accept responsibility for the practice of those students.

3. Faculty

a. Responsibilities
In each location where students are assigned for didactic or clinical instruction or supervised practice, there shall be instructional faculty designated to coordinate supervision and provide frequent assessments of the students' progress in achieving acceptable program requirements.

"Instructional Faculty" includes paid or unpaid part-time or adjunct faculty, instructional staff, preceptors, or any other title associated with the individual responsible for the supervision and/or assessment of the student.

b. Qualifications
The faculty must be knowledgeable in course content and effective in teaching their assigned subjects, and capable through academic preparation, training and experience to teach the courses or topics to which they are assigned.

For most programs, there should be a faculty member to assist in teaching and/or clinical coordination in addition to the program director. The faculty member should be certified by a

nationally recognized certifying organization at an equal or higher level of professional training than the Emergency Medical Services Profession(s) for which training is being offered.

C. Curriculum

1. The curriculum must ensure the achievement of program goals and learning domains. Instruction must be an appropriate sequence of classroom, laboratory, clinical, and field/internship activities. Instruction must be based on clearly written course syllabi describing learning goals, course objectives, and competencies required for graduation.

   Progression of learning typically involves didactic/theory followed by laboratory practice followed by clinical experience followed by field internship.

   The program must demonstrate by comparison that the curriculum offered meets or exceeds the content and competency demands of the latest edition of the United States Department of Transportation, National Highway Traffic Safety Administration, National Emergency Medical Services Core Content, Scope of Practice Model, and Education Standards, and the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions Curriculum Supplement.

   The required curriculum content topics should be documented through course syllabi, lesson plans, supplemental instructional materials, textbooks, reference materials, etc, which lead to accomplishment of the program goals and outcomes.

- *Emergency Medical Technician-Paramedic*

  Accredited programs typically range from 1000-1300 clock hours, including the four integrated phases of education (didactic, laboratory, and clinical and field) to cover the stated curriculum. Further pre-requisites and/or co-requisites may be required to address competencies in basic health sciences (Anatomy and Physiology) and in basic academic skills (English and Mathematics) and together with the core content of the Emergency Medical Technician-Basic and Emergency Medical Technician-Paramedic curricula may lead to an academic degree.

- *Emergency Medical Technician-Intermediate*

  The current national curriculum recommends 300-400 clock hours, including the four integrated phases of education (didactic, laboratory, and clinical and field) to cover the stated curriculum. Further pre-requisites and /or co-requisites may be required to address competencies in basic health sciences (Anatomy and Physiology) and in basic academic skills (English and Mathematics) and together with the core content of the Emergency Medical Technician-Basic and the Emergency Medical Technician-Intermediate curricula may lead to an

academic certificate or degree. *For those programs offering an exit point at the Emergency Medical Technician-Basic level, the current national curriculum for Emergency Medical Technician-Basic recommends 110 clock hours of integrated didactic and laboratory instruction. Clinical/field rotations should be of sufficient length to allow students to interview and assess a minimum of five patients. For those programs offering an exit point at the First Responder level, the current national curriculum for First Responder recommends 40 clock hours of integrated didactic and laboratory instruction. For further details on these curricula, see the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions website at www.CoAEMSP.org.*	
2. The program must track the number of times each student successfully performs each of the competencies required for the appropriate exit point according to patient age, pathologies, complaint, gender, and interventions.	2. There must be a tracking system: either paper or computer based. The program must establish the minimum number of encounters for each of the competencies for each of the defined distributions. (see Interpretation III.A.2) The tracking system must incorporate and identify the minimum competencies (program minimum numbers) required for each exposure group, which encompasses patient age (pediatric age subgroups must include: newborn, infant, toddler, preschooler, school-ager, and adolescent), pathologies, complaint, gender, and intervention, for each student. Intervention tracking must include airway management with any method or device used by the program. The tracking system must clearly identify those students not meeting the program minimum numbers.
3. The field internship must provide the student with an opportunity to serve as team leader in a variety of pre-hospital advanced life support emergency medical situations. *Enough of the field internship should occur following the completion of the didactic and clinical phases of the program to assure that the student has achieved the desired didactic and clinical competencies of the curriculum prior to the commencement of the field internship. Some didactic material may be taught concurrent with the field internship.*	3. The field internship site must allow students to assess and manage patients in the pre-hospital environment where he/she will progress to the role of Team Leader. Minimum team leads must be established by the program and accomplished by **each** student. The number of team leads is established and analyzed by the program through the program evaluation system and must reflect the depth and breadth of the paramedic profession. The program must show that the timing and sequencing of the team leads occur as a capstone experience and in relation to the didactic and clinical phases of the program so as to provide an appropriate experience to demonstrate competence. Evaluating the effectiveness of being a team lead is under standard IV.A.1 and IV.A.2.
D. Resource Assessment The program must, at least annually, assess the appropriateness and effectiveness of the resources described in these standards. The results of	D. The resource assessment surveys must be administered at least annually and be reflected in an on-going resource assessment matrix. The completed matrix must be presented to the Advisory Committee as part of the evaluation system. Recognized deficiencies must

resource assessment must be the basis for ongoing planning and appropriate change. An action plan must be developed when deficiencies are identified in the program resources. Implementation of the action plan must be documented and results measured by ongoing resource assessment.	have an action plan and a method of review to ensure the deficiency is corrected.
IV. Student and Graduate Evaluation/ Assessment **A. Student Evaluation** **1. Frequency and Purpose** Evaluation of students must be conducted on a recurrent basis and with sufficient frequency to provide both the students and program faculty with valid and timely indications of the students' progress toward and achievement of the competencies and learning domains stated in the curriculum.	1. There are many types of evaluations that are required by the CoAEMSP. Achievement of the competencies required for graduation must be assessed by program criterion-referenced, summative, comprehensive final evaluations. **Summative program evaluation is a capstone event that occurs when the field internship is nearing completion.** Summative comprehensive evaluation must include cognitive, psychomotor, and affective domains. **Didactic/Cognitive Evaluation** (see also IV.A.2-Documentation) The didactic evaluation system must include both formative and summative types of evaluations (e.g. quizzes, exams). There should be a progression in the level of questions toward higher levels of critical thinking. The examinations must be reviewed for validity and medical accuracy. The Medical Director must review the medical content and accuracy of the examination system. These activities must be documented [see III.B.2.a.2)] Validity must be demonstrated on major exams, but methods may vary depending on the number of students. All exams should be reviewed by item analysis, which **may** include difficulty index (p+) and discrimination index (point bi-serial correlation). For programs using a commercial testing product, the program must demonstrate, through the program's own item analysis, that the test items used are valid and reliable for the program. Simply quoting the national validity and reliability information provided by the vendor does not adequately establish that the test items are valid and reliable for the specific curriculum of the specific program. The results of the review (based on program established criteria) must be documented as well as any changes to exams that resulted from the review. Programs with large enrollments may be able to employ recognized mathematical formulas. **Psychomotor Evaluation** (see also IV.A.2-Documentation) The program needs to have a system that shows that the student moves from novice to entry level competence for each skill. The frequency of evaluations is determined by

each program; however certain evaluations are required.

The program must designate the minimum number of times that each student must successfully perform each skill.

The program must be able to justify its numbers, which may relate to the national standards, local community needs, input from the Advisory Committee and/or approval by the Medical Director.

Affective Evaluation (see also IV.A.2-Documentation)
As important as the cognitive and psychomotor domains, the program must teach, monitor, and evaluate (i.e. grade) the attitudes and behaviors of the students, including interpersonal interactions. There must be at least one comprehensive affective evaluation of each student, separate from affective components of clinical/field evaluations. The program must maintain records of the regular affective evaluations.

On-going, documented affective evaluations must be done that assess student behaviors for all learning settings (i.e., didactic, laboratory, clinical, and field) with combined or separate instruments. The affective evaluation items may be incorporated with other evaluations (e.g., skill, competency, field internship). The frequency of the evaluations need to be done in a timely manner to provide the student and at least the program director and medical director with his/her performance/ progress throughout the program. These periodic affective evaluations are in addition to the required summative, comprehensive affective evaluation at the end of the program.

When the program determines that a student is not exhibiting appropriate behaviors, there must be evidence of counseling to attempt to correct the behavior, when appropriate, and continued evaluation of successful remediation or academic action (e.g. probation, failure).

Terminal Competence
The program must document that all students have reached terminal competence as an entry level paramedic in all three learning domains.

Determination of terminal competence is a joint responsibility of the program and the medical director. The Medical Director must certify and document terminal competence. [see III.B.2.a.4)].

2. Documentation
Records of student evaluations must be maintained in sufficient detail to document learning progress and achievements.

2. The program must have adequate methods to document those items described in Standard IV.A.1.

Didactic/Cognitive Documentation
The program must keep a master copy of all exams used in the program. Also, the program must maintain a record of student performance on every didactic evaluation.

Psychomotor Documentation
The program must keep a master copy of all psychomotor evaluation instruments used in the program. Also, the program must maintain a record of student performance on every psychomotor evaluation. The record could be a summary of scores or the individual graded skill sheets.

Documentation should show progression of the students toward terminal competency.

Affective Documentation
The program must keep a master copy of all affective evaluation instruments used in the program. Also, the program must maintain a record of every student's affective evaluation(s).

Evaluations of all learning domains should be reviewed with students in a timely fashion. Evidence of review is required.

A record of all counseling and the results must be maintained by the program.

It is expected that the school will meet with each student at least once each academic session (e.g., semester, term, quarter) in sufficient time that the student can adequately respond to the counseling, as needed.

Counseling includes, but is not limited to, exchange of information between program personnel and a student providing academically related advice or guidance for each of the three learning domains.

The school needs a policy on when student counseling will occur, such as

- Routinely during an academic session (e.g., semester, quarter, term)
- including as part of due process for disciplinary proceeding
- academic deficiencies and the path for improvement
- other issues that interfere with the teaching/learning process
- the academic status of the student and what must occur for academic success in the course and/or program
- a status assessment of the student's academic progress for each learning domain

The documentation of counseling session should include at a minimum:

- The date of the counseling session
- The reason for the counseling session
- The essential elements of the discussion of the counseling, including corrective action and the timeline for that action
- The decision of the result of the counseling
- The signature of the school official doing the counseling
- The student's response to the counseling
- The signature of the student acknowledging receipt of the counseling completed form.

Field Internship Documentation
The program must keep a master copy of all field internship evaluation instruments used in the program. Also, the program must maintain a record of student performance on every field internship evaluation. The record could be a summary of scores or the individual evaluation instruments.

Documentation should show progression of the students to the role of team leader as required by the program.

The program must document a mechanism for demonstrating consistency of evaluation and progression of the student during team leadership.

Terminal Competence Documentation
The program must have a document signed by the Medical Director and the Program Director showing that the student has achieved the established terminal competencies for all phases of the program.

B. Outcomes

1. Outcomes Assessment

The program must periodically assess its effectiveness in achieving its stated goals and learning domains. The results of this evaluation must be reflected in the review and timely revision of the program.

Outcomes assessments include but are not limited to: exit point completion, graduate satisfaction, employer satisfaction, job placement, state licensing examinations and/or national registration.

1. Programs seeking Initial Accreditation are not required to have outcomes data, but must have a plan as to how they will collect and analyze the data upon achieving Initial Accreditation.

2. Outcomes Reporting

The program must periodically submit its goal(s), learning domains, evaluation systems (including type, cut score, validity, and reliability), outcomes, its analysis of the outcomes and an appropriate action plan based on the analysis.

Program evaluation should utilize certification examinations developed by an independent national organization that employ cut scores based upon a valid psychometric formula which judges entry level competence and uses practice analysis consistent with the description of the profession. Examinations should be national in scope with uniform passing standards and statistical reports. Cognitive instruments should reflect the Standards for Educational and Psychological Testing of the American Psychological Association. Psychomotor evaluations should be course ending, should be conducted by personnel not directly involved in student education, and should have a defined method of administration well known to students. Affective domain instruments should be approved by the program's communities of interest and should be tied to employer and graduate surveys.

2. The data reported in the annual report by programs achieving Initial Accreditation begins from the date that CAAHEP awards the Initial Accreditation.

Continuing Accreditation programs are notified by the CoAEMSP each year as to the due date of the Annual Report submission. The most recently filed Annual Report is added to the Continuing-Accreditation Self Study Report (CSSR), when a continuing program undergoes comprehensive review.

Starting in 2015, all accredited programs must publish, preferably in a readily accessible place on their websites, the 3-year review-window average results of the outcomes for:

- NREMT or State (as applicable) Written and Practical pass rates, and
- retention, and
- positive placement

At all times, the published results must be consistent with and verifiable by the online Annual Report of the program.

Starting with the 2015 annual report, each year in the Comments tab of the on-line Annual Report, the program must state the website link (or other publication) where its results are published.. If the program uses a means other than its website, it must describe those means in the Comments tab, and submit/upload as Related Documents, the materials by which it publishes the outcome results.

Failure to meet the defined outcomes threshold over the most recent 3 year average may be considered by the CoAEMSP to be a Standards violation.

Program evaluation should be a continuing and systematic process with internal and external curriculum validation in consultation with employers, faulty, preceptors, students, and graduates. Other dimensions of the program may merit consideration such as the admission criteria and process, the curriculum design, and the purpose and productivity of an advisory committee.	
V. Fair Practices **A. Publications and Disclosure** 1. Announcements, catalogs, publications, and advertising must accurately reflect the program offered.	
2. At least the following must be made known to all applicants and students: the sponsor's institutional and programmatic accreditation status as well as the name, address and phone number of the accrediting agencies, admissions policies and practices, including technical standards related to the functional job analysis(es) of the Emergency Medical Services Profession(s) for which training is being offered; policies on advanced placement, transfer of credits, and credits for experiential learning; number of credits required for completion of the program; tuition/fees and other costs required to complete the program; policies and processes for withdrawal and for refunds of tuition/fees.	2. The statement of program accreditation must be in accordance with CoAEMSP policy IV.A.3. The statement of a program holding a Letter of Review (LoR) must be made in accordance with CoAEMSP policy I.B.3. **All students who are accepted for advanced placement (AP) must be accounted for in the annual report. Programs must demonstrate how advanced placement graduates meet all program minimum competency requirements in didactic, lab, clinical, and field internships. All programs must have and publish their policy on advanced placement even if they do not utilize advanced placement.**
3. At least the following must be made known to all students: academic calendar, student grievance procedure, criteria for successful completion of each segment of the curriculum and graduation, and policies and processes by which students may perform clinical work while enrolled in the program.	
B. Lawful and Non-discriminatory Practices All activities associated with the program, including student and faculty recruitment, student admission, and faculty employment practices, must be non-discriminatory and in accord with federal and state statutes, rules, and regulations. There must be a faculty grievance procedure made known to all paid faculty.	
C. Safeguards The health and safety of patients, students, and faculty associated with the educational activities of the students must be adequately safeguarded. All activities required in the program must be educational and students must not be substituted for staff.	C. For educational activities, individuals must be clearly identified as students, in a specified clinical/field experience/internship, under the auspices of the program medical director, and under the supervision the designated preceptor prior to performing patient care. Students must not be substituted for staff .

Medical control/accountability exists when there is unequivocal evidence that Emergency Medical Services Professionals are not operating as independent practitioners, and when Emergency Medical Services Professionals are under direct medical control or in a system utilizing standing orders where timely medical audit and review provide for quality assurance.	
D. Student Records Satisfactory records must be maintained for student admission, advisement, counseling, and evaluation. Grades and credits for courses must be recorded on the student transcript and permanently maintained by the sponsor in a safe and accessible location.	
E. Substantive Change The sponsor must report substantive changes as described in Appendix A to CAAHEP/CoAEMSP in a timely manner. Additional substantive changes to be reported to CoAEMSP within the time limits prescribed include: change in program status, sponsorship, or administrative personnel.	
F. Agreements There must be a formal affiliation agreement or memorandum of understanding between the sponsor and all other entities that participate in the education of the students describing the relationship, role, and responsibilities between the sponsor and that entity. *Entities that participate include: hospital/clinical sites and field/internship sites.*	F. There must be current affiliation agreements with clinical affiliates and field internship sites that define the responsibilities of both the program and the sponsor, detailing what the students can do at the site, and the responsibilities of the preceptor. NOTE: If the sponsor is a consortium, the agreements must be with the consortium, in the name of the consortium, and signed by the Chair of the consortium governing body, on behalf of the consortium sponsor. Contracts may have automatic renewal provisions, but the program should show evidence of periodic review that the affiliation continues to meet the needs of the program. If the program uses a secure electronic signature, documentation of the agreement must exist between the parties allowing for such signature. A secure electronic signature is **not** a jpeg or other type of image attached to a document. A secure electronic signature is unique and under the sole control of the individual making the signature, the technology used must be able to identify the person making the signature, and the technology must be able to identify if the document was changed in any way after the electronic signature was applied.