How Do I?

A Summary of Program Management Activities

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Reviewing the Commission on Accreditation of Allied Health Education Programs (CAAHEP) *Standards and Guidelines for the Emergency Medical Services Professions* may prompt the question, "How should I do that?" There is no single way; it's about process and outcomes, not a specific format or content. The Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) provides standardized forms like graduate and employer surveys to ensure consistent information collection and reporting in specified areas. In others, you decide the approach. Ensure your process meets the program's needs and the CAAHEP *Standards*. This article addresses common questions and clarifications.

Structural/Foundational, Process, or Detail-Specific?

Program standards can be categorized into three types: *structural/foundational*, *process*, and *detail-specific*. For example, the roles and functions of a medical director or program director are essential to the *structure and foundation* of the program. Tracking clinical contacts and assessing the achievement of competencies require an adequate *process* to ensure attainment and documentation. Notifying students of fair practices and other policies can be viewed as attending to the program *details*. Assessing your program according to these three categories can help identify where to begin with a program evaluation, determine initial priorities if implementation is needed, and highlight any significant resources that may be lacking. For example, adding language to the program policy manual that addresses providing a functional job description or the institution's non-discriminatory practices is a quick and easy *Standards* compliance issue. Getting active involvement from the program medical director can be much more challenging, may be a long-term project, and may require more financial resources.

As you evaluate where you are and where you need to be regarding meeting all the *Standards*, identify the issues as *foundational*, *process*, or *detail*. Many items and issues may have elements in each category, and it is important to recognize the overlapping areas. For example, having "access to adequate numbers of patients, proportionally distributed by age-range, chief complaint, and interventions in the delivery of emergency care appropriate to the level of the emergency medical services profession(s) for which training is being offered" is a *Standard*. This requires adequate clinical sites to provide the necessary student experience (a *foundation*) and personnel to supervise the students (a *foundation*). However, it also requires a method to track clinical experiences (a *process*).

The following briefly discusses some of the more common questions and issues that arise in program review.

Sponsor

The issue of sponsorship of an EMS educational program is foundational. Review the *Standards* language regarding acceptable qualifying sponsors at http://www.coaemsp.org/Standards.htm. Also, review the *Interpretations* of this *Standard* on the same page. CAAHEP provides *programmatic* accreditation, which is distinct from *institutional* accreditation. Both are paths to evaluating our programs against our industry standards and evaluating ourselves against accepted standards of institutions of higher learning regarding appropriate educational processes.

Program Goals

All programs are required to identify expectations and goals established for the program. CAAHEP has established the minimum required expectation (goal) for all programs:

> Paramedic: "To prepare Paramedics who are competent in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains to enter the profession."
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> Advanced Emergency Medical Technician: "To prepare Advanced Emergency Medical Technicians who are competent in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains to enter the profession."

In consultation with their Advisory Committee and sponsors, programs may establish additional goals. However, all goals must be evaluated at least annually by a mechanism that provides quantifiable data. Programs are advised to consider whether the identified goals are programmatic, institutional, goals for individual courses, or faculty or staff goals. All are appropriate, but programmatic goals must be reported and evaluated. It is also essential for students to understand the goals, which should be outlined in program materials and syllabi, emphasized throughout the course, and reflected in policies.

Advisory Committee

The role of an Advisory Committee is to provide input, guidance, and recommendations regarding your program and to review and revise the program goals as necessary. For an Advisory Committee to be maximally effective, a broad representation of the communities of interest is vital. The communities of interest required in the *Standards* include students, graduates, faculty members, sponsor administrators, employers, physicians, clinical and capstone field internship representatives, and the public. Each category must have at least one representative, but the program may include multiple representatives to reflect their communities of interest. Representatives of the program and sponsor participate and are ex-officio members. The chair of the committee should be from one of the external communities of interest and not the program or sponsor. The public member is an individual who has no current or previous affiliation with emergency services or healthcare and who provides an 'outside' or consumer perception that is valuable.

The charge of the Advisory Committee is to advise the program regarding revisions to curriculum and program goals based on the changing needs and expectations of the program's communities of interest and an assessment of program effectiveness, including the outcomes specified in the *Standards*.

The Advisory Committee meetings provide an opportunity to update the representatives on program activities, and should primarily serve to evaluate the program, review progress toward the goals, and discuss the future.

Resources

Financial

Emergency medical services educational programs require significant resources, especially in terms of financial variety, and everyone has a stake in the continued existence and longevity of the program.

Facility

An important resource is the facility itself, where education occurs. Is there a sufficient and acceptable classroom environment that is conducive to learning? What are the areas/opportunities for skill practice? EMS education requires space and the ability to create realistic learning environments for simulations and scenarios. A class of twenty students, for example, typically requires the availability of at least four separate practice locations. Dividing the classroom into four quadrants with multiple activities simultaneously may not provide the necessary opportunity for practice, feedback, or privacy for testing and skill evaluation. An area for break and study is ideal. Students also need access to computers, whether provided by the program or as a requirement for personal devices.

Practical Experience

Practical experience is divided into two primary components: the hospital clinical areas (or clinic-type locations) and field experience, and the capstone field internship. Some programs may use different agencies for field experience and the capstone phase. The field *experience* rotation is intended to facilitate acclimatization to the prehospital environment and to allow the student to develop assessment and intervention skills. The capstone field internship places the student in the team leader role with minimal preceptor intervention. The student must complete all assessments, interventions, and other skills the program requires and demonstrate competency in team leads. The capstone field internship occurs after all clinical content of the curriculum has been completed and the individual is prepared to assess and manage all patient ages, types, and conditions.

Personnel

The next resource is personnel, including program director, faculty, and administrative support. The accrediting body does not define staffing levels; however, the number and qualifications of the personnel must be adequate to ensure that the

program goals are met. What should program staffing include? Program structures and schedules vary, but it is recommended that the program director is a full-time position. The duties and responsibilities of the program director are specified in the *Standards*. Teaching loads/assignments for the program director vary and determine the need for additional full-time faculty. The program director is responsible for monitoring faculty, adjunct instructors, and guest presenters. The *Standards* also require that clinical coordinator responsibilities are assigned to a faculty member.

Every staff and faculty member should have a job description that outlines the role's responsibilities and specifies a performance evaluation method.

Program Director

The program director is responsible for orienting clinical liaisons and training capstone field internship preceptors. The duties can be delegated, and oversight remains with the program director. The minimal required components of the orientation and training are specified in the *CoAEMSP Interpretations of the CAAHEP Standards* document. The clinical and field experience and capstone field internship are core components of the educational program, and much of the oversight and supervision is in the hands of these preceptors. It is important that capstone field internship preceptors are chosen carefully when possible and that they are informed of the curriculum, expectations of the students, the role of the preceptor, coaching students, evaluating students, problem identification and resolution of problems, evaluation paperwork, and other programmatic issues. As preceptors oversee and assess students, inter-rater reliability is crucial to ensure that competency is evaluated consistently for each student in every situation. An ideal method is a face-to-face or live video conferencing preceptor training session that provides the opportunity for discussion, role-playing, and direct delivery of content. An online course provides convenience but lacks interaction. Regardless of the method, the best practice is to provide a written program manual for reference as needed. Several methods of meeting the preceptor training requirement are described in the *CoAEMSP Interpretations of the CAAHEP Standards* and can be found on the CoAEMSP website at http://www.coaemsp.org/Standards.htm.

Medical Director

The medical director is responsible and accountable for the medical aspects of the program. Finding a medical director with the interest, time, and expertise to fulfill the role can be challenging. The medical director cannot delegate these responsibilities to the program director or faculty. The medical director must be involved in the program: review and approve the educational content of the program to include didactic, laboratory, clinical experience, field experience, and capstone field to ensure it meets current standards of medical practice; review and approve the required minimum numbers for each of the required patient contacts and procedures; review and approve the instruments and processes used to evaluate students in didactic, laboratory, clinical, field experience, and capstone field internship; and review the progress of each student throughout the program, assist in the determination of appropriate corrective measures; ensure the competence of each graduate of the program in the cognitive, psychomotor, and affective domains; engage in cooperative involvement with the program director; and ensure the effectiveness and quality of any medical director responsibilities delegated to an associate or assistant medical director.

The program director and medical director should regularly meet with a specified agenda or to-do list and document their activities and decisions.

Curriculum

A curriculum is comprised of a set of courses and their content. For the emergency medical services professions, the curriculum is defined by the *National EMS Education Standards,* and the students must be successful in all the program components. The sequence of courses and content must follow a logical order. The order of the didactic, laboratory, clinical, and field internship may be integrated, and it must be sequential and build on the content and skills developed in the previous units/modules/components. The capstone field internship occurs ***after*** all medical content and clinical experiences are completed. The capstone field internship provides an opportunity to integrate all previous knowledge and experiences to allow the student to function competently as a team leader.

The road map for the didactic and lab experiences is the lesson plan. An effective lesson plan is instructor-developed using multiple resources to facilitate learning and does not rely solely on a textbook. The student has the textbook; the instructor should bring additional insights and resources to the topic, and that information is captured in a lesson plan.

If the lesson plan is the road map for the instructor, the course syllabus is the map for the student. A well-developed syllabus guides the students through the course content and makes all expectations and requirements clear.

Clinical and Field Internship Sites

Quality clinical and field experience/capstone field internship sites are crucial and are often built on relationships. The objective is to find resources with personnel and preceptors committed to teaching, adequate volume, and appropriate types of patients and procedures to provide the opportunity to develop competency and offer locations that are convenient for program faculty to supervise the learning experience. Investigate non-traditional resources for assessment experiences such as child day care centers, nursing homes, clinics, urgent care facilities, and other unique environments. There must be a current signed and dated legal agreement with each site where students are assigned for clinical and field rotations. The agreement must detail the responsibilities of the program and the agency. Effective agreements are reviewed and renewed periodically and have a defined expiration date.

Program Assessment

The education process itself changes and evolves. Students/learners are assessed frequently with quizzes, exams, skill evaluations, clinical evaluations, field evaluations, and other tools. The program needs to be evaluated frequently, by both formal and informal mechanisms. Formal evaluation includes the CoAEMSP *Annual Resource Assessment* completed by the program staff, medical director, and Advisory Committee and is summarized into the *Resource Assessment Matrix* (RAM). A second tool is the *Graduate and Employer Surveys,* which should be delivered no earlier than six months post-graduation but not longer than twelve months. A SWOT analysis is also a useful tool. In this

method, stakeholders and staff identify the program strengths (S), weaknesses or limitations (W), opportunities (O), and threats (T). The resulting lists (frequently structured as a chart with four quadrants) provide a quick, graphic depiction or snapshot of the current state. Assessment should be viewed as a dynamic process. For example, a weakness, such as limited clinical facilities, may drive staff to explore an opportunity to develop new sites. Remember that additional evaluation includes, at a minimum, student evaluation of instructional faculty, student evaluation of the clinical and field internship sites and experiences, student evaluation of preceptors, and administrative evaluation of faculty.

Student Assessment

Things You Must Do

The number of times an individual performs a procedure does not determine competency. However, without the ability to keep students in the clinical and field areas under direct observation, in a variety of situations and settings, indefinitely until we are satisfied that competency has been attained in each skill each time, we rely on numbers. Programs are required to use the CoAEMSP *Student Minimum Competency* recommendations as a baseline. CoAEMSP *recommends* minimum numbers, but the program establishes the *required* minimums that all graduates must meet. If a program elects to identify numbers that are less than the recommendations, it must be able to defend the minimums chosen. All students **must** reach each minimum requirement. Minimum numbers may be revisited periodically in consultation with the medical director and the Advisory Committee, and changes may be made based on the evaluation of student competency. Careful tracking and documentation throughout the educational process is required, with ongoing assessment of progress toward the minimums and opportunities for additional experience as necessary. Students enter their data, but the process requires frequent staff review to determine if students meet the expected minimums.

Cognitive testing plays an essential role in student assessment. While utilizing test banks or other published materials may be convenient, it is important to consider whether these questions effectively evaluate the student's knowledge and foster their critical thinking skills. Are the items appropriately written? Is there a correct answer, and are the distracters plausible? Whatever method you use, carefully evaluate the items you choose and have the faculty and medical director review the items to decide the degree of difficulty, that the question clearly tests important concepts, and that there is a right answer that all agree to. Following administration, the program must evaluate all exams for reliability and validity, even commercial items or test banks.

Document Activities

Students are told, “If you didn’t document it, you didn’t do it.” EMS educational programs must subscribe to the same dictum. Develop a mechanism to document the assessments, evaluations, discussions, and changes you implement. Date all documents with the original development date and, at a minimum, the latest revision. With all program changes, ask: “How will we document this for future reference?” Keep detailed minutes of staff meetings, meetings with the medical director, student conferences and counseling, Advisory Committee meetings, and analysis of surveys and assessments with resulting changes. One quick test is to ask: “If I was coming to this job with no prior knowledge of this

program or how it has operated, what information would be useful for me?" Program documentation is not just for the CoAEMSP site visit; its importance lies in the longevity and sustainability of the program.

The second category of documentation relates to documentation of student/learner competencies. Records should show student/learner progression, evaluation at milestones, counseling, and all aspects of terminal evaluation, including summative written exam, summative final practical exam, summative affective evaluation, skill attainment, capstone field internship evaluation, and any other mechanisms such as final oral examination or other gatekeeper events.

Resources

CoAEMSP provides various resources to assist a program with new or continuing accreditation, so become thoroughly familiar with the CoAEMSP website at www.coaemsp.org. Check regularly for changes, updates, and new tools.

Summary

Accreditation is an opportunity to continue to develop your program and to bring new insights. Approach your preparation with an attitude of "How do I?" rather than "But we can't do that/that won't work," and you will be well on your way to a better program. And evaluate issues as *structural/foundational*, *process*, or *detail-specific* and develop the appropriate plan.