How Do I…

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Ever heard the expression: "There are many ways to..?" Well you get the idea. As you review the Commission on Accreditation of Allied Health Education Programs (CAAHEP) *Standards and Guidelines*, a frequent refrain may be: "But how should I do that?" The correct answer is that there is **no one way,** it is about process and outcomes, not a specified format or content. Over time, the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), who works under the auspices of CAAHEP, has developed a variety of standardized forms, such as graduate and employer surveys, to aid in the consistency of information collected and reported. However, in other areas, the path is up to you. Remember, any process must meet the needs of your program as well as the CAAHEP *Standard*. This article addresses common questions and areas that are sometimes stumbling blocks.

Program standards may be loosely categorized into three types: *structural/foundational*; *process*; and *detail* specific. For example, the roles and function of a Medical Director or Program Director is core to the *structure and foundation* of the program. The tracking of clinical contacts and assessing the achievement of competencies requires an adequate *process* to ensure attainment and documentation. Notification to students of fair practices and other policies can be viewed as attending to the program *details*. Evaluating your program in relation to these three categories may be beneficial in determining where to start with a program assessment; what to tackle first if implementation is required and what significant resources may be missing. For example, adding language to the program policy manual that addresses providing information on the paramedic functional job description or the institution's non-discriminatory practices is clearly a quick and easy *Standards* compliance issue. Getting active involvement of the program Medical Director can be much more daunting and may be a long term project and require more financial resources. As you evaluate where you are and where you need to be in regard to meeting all the *Standards*, identify the issues as: *foundational*, *process*, or *detail*. Of course, many items and issues may have elements in each of these categories and it is important to recognize the overlapping areas. For example, having 'access to adequate numbers of patients, proportionally distributed by illness, injury, gender, age, and common problems' is a *Standard*. This requires adequate clinical sites to provide the necessary student experience (a *foundation*) and also personnel to supervise the students (a *foundation*). But it also requires a method to track the clinical experiences (a *process*).

Following is a brief discussion of some of the more common questions and issues that arise in program review.

SPONSOR

The issue of sponsorship and who or what type of organization is an acceptable sponsor, can be a thorny issue. Review the *Standards* language regarding acceptable qualifying sponsors at: http://www.coaemsp.org/Standards.htm. Also review the Interpretations of this *Standard* at: he same site. CAAHEP provides *programmatic* accreditation: it is important that the paramedic program be part of a system that provides *institutional* accreditation. Both are paths to evaluating our programs against our industry standards, but also to evaluating ourselves against accepted standards of institutions of higher learning regarding appropriate educational processes. The standard for an accrediting body of institutions of higher learning is an approving body authorized to provide post-secondary education. A list of approved accrediting organizations can be found on the US Department of Education web site: http://www.ope.ed.gov/accreditation/.

PROGRAM GOALS

All programs are required to identify goals established for the program. There is help for this one. The CAAHEP has established the minimum goals: To prepare competent entry-level Emergency Medical Technician-Paramedics in the cognitive, psychomotor, and affective learning domains. Programs, in consultation with their Advisory Committee and program sponsors, may establish additional goals. However, all goals must be evaluated at least annually by a mechanism that provides quantifiable data and that data must be summarized in the mandatory CoAEMSP *Annual Report*. Programs are advised to consider whether the identified goals are: programmatic goals, institutional goals, goals for individual courses, or faculty or staff goals. All are appropriate, but programmatic goals must be reported and evaluated. Additionally, it is important that students understand the goals so they should be presented to each class and described in program materials and syllabi, reinforced throughout the course, and reflected in policies.

Advisory Committee

What is an Advisory Committee really? This *Standards* requirement is frequently misunderstood. The role of an Advisory Committee is simple: to provide input, guidance, 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. What exactly does this mean? A community of interest may be defined as: a community of people who share a common interest or passion. Practically speaking, how does this relate to your program? The first question is 'who are the individuals most impacted by our program?' The answers will vary but probably include the individuals in the following categories. Area employers should be a primary component, both in numbers and sources (who better to provide feedback on how your graduates – or your *product* – function in the field?) The hospitals or other clinical areas where students complete clinical

rotations must be participants: this includes both nursing and physician representatives. These individuals can provide important information on this critical student experience. Some of the EMS agencies that provide field internship for your students may not be agencies that hire your graduates but should be included. Graduates provide an additional view point and should represent the more recent (and therefore, more relevant) perspectives on the current program. Someone representing the general public is a common addition to any Advisory Committee to provide an 'outside' or consumer perception that is valuable. Depending on your location, relationships, and circumstances, representatives from other groups such as the local law enforcement community may be appropriate. Remember, program faculty and administration representatives are basically ex-officio members. The Advisory Committee meetings provide a time to update the representatives on your activities, but should primarily serve to evaluate the program, review progress toward the goals, and discuss the future. And lastly, the committee should select a chair that is not a faculty member or representative of the program: the chair should come from the communities of interest.

RESOURCES

Financial (or why do they need to see our budget?)

Paramedic education programs require significant resources, especially of the financial variety and everyone has a stake in the continued existence and longevity of the program. The CoAEMSP begins evaluating the organizational commitment by determining if an ample budget is provided.

Facility

The next resource is the facility itself where the education occurs. Is there a sufficient, and acceptable, classroom environment that is conductive to learning? And what are the areas/opportunities for skill practice? EMS education requires more than just seat room for learners – it requires lots of space and the ability to create realistic learning environments for simulations and scenarios. A class of twenty students for example, requires the availability of at least four separate practice locations. Dividing the classroom into four quadrants with multiple activities at the same time does not typically provide the necessary opportunity for practice or feedback or for testing or skill evaluation. Learners also need an area or areas for break and study. In this electronic age, they also need access to computers in or near the education facility.

Practical Experience

Practical experience is divided into two primary, and vital, components: the hospital clinical areas (or a clinic) and the field internship experience. Some programs separate the field experience into field *clinical* and field *internship* sections. The field *clinical* rotation is intended to facilitate acclimatization to the prehospital environment and to allow the student to develop assessment and intervention skills. The field *internship* then places the student in the role of *team lead* with, hopefully, minimal intervention from the preceptor. The student must

complete all assessments, interventions, and other skills required by the program and must demonstrate competency in their team leads. And this field internship takes place ***at the end of the program*** after completion of the didactic and clinical portions.

Personnel

The next resource is personnel, including Program Director, faculty, and clerical support. Staffing levels are not defined by the accrediting body, but the number and qualifications of the personnel must be adequate to ensure that the program goals are met. So to produce competent, entry-level paramedics, what should program staffing include? Unless the course follows an extremely part-time structure, the Program Director should be a full-time employee. The duties and responsibilities of the Program Director are many and this individual should be readily available to the students and staff. Teaching loads/assignments for the Program Director vary and will determine the need for additional full-time faculty. In general, if the Program Director has a minimal teaching assignment with the program, there should be a full-time lead instructor or coordinator. Even if guest or adjunct instructors are used, the lead instructor or coordinator is responsible to monitor those sessions and ensure that content is appropriately covered. An identified clinical coordinator is also a necessity: the number of hours will depend on the clinical/field schedule and the number of students in the program. Each of these individuals should have a job description and a list of responsibilities of the role and an identified method of performance evaluation.

One of the sometimes overlooked responsibilities of the Program Director is the training of preceptors. Because preceptors are considered personnel, the appropriate orientation and training of these vital individuals is included in the Program Director responsibilities. The clinical and field experience is a core component of the paramedic educational program and the majority of the oversight and supervision is in the hands of these preceptors. It is therefore important that, just like faculty, preceptors are chosen carefully and oriented to the needs of the program including: 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. Since preceptors supervise and evaluate students, inter-rater reliability is essential to ensure that competency is being determined the same way for each student in each situation. The ideal way to accomplish this is by a face-to-face preceptor training program that provides opportunity for discussion and role playing scenarios in addition to direct delivery of content. An emerging option is an online course which obviously provides additional convenience but lacks the interaction. Regardless of the method used, anyone serving in a preceptor role should be provided with 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 Guidelines* and can be found on the CoAEMSP webpage at: http://www.coaemsp.org/Standards.htm.

In an EMS system, the Medical Director is responsible for the medical actions and acts of a paramedic. Therefore, in the educational process, the Medical Director must be responsible and accountable for all medical aspects of the program that educates paramedics. It can be

easy to find ***a*** Medical Director but may be much more difficult to find ***the*** Medical Director with the interest, time, and expertise to fulfill the role. It is not enough for the Medical Director to say "I delegate these responsibilities to the Program Director and faculty'. He or she must be involved in all aspects of the program: review and approval of the educational content, review of testing and evaluation materials, evaluation of the quality of medical instruction, review and approval of the progress of each student throughout the program, program evaluation, and the final determination of student competency – for all students, not just the ones observed on a haphazard basis while working in the emergency department, for example. Meet regularly with the program Medical Director with a specified agenda or to-do list and document the activities and decisions. Some meetings or communications may be electronic, but however you meet, it is important to document all interactions. Once again, refer to the *CoAEMSP Interpretations of the CAAHEP Standards and Guidelines* found on the CoAEMSP webpage at: http://www.coaemsp.org/Standards.htm for additional guidance.

Curriculum

A curriculum is comprised of a set of courses and their content. In the emergency medical services world, the curriculum is defined by the *National EMS Education Standards* and the students must pass all the program components to successfully complete the course of study. So if the curriculum is the whole, how do we address the parts? Several tools are required to make a cohesive foundation for EMS students. First, the sequencing must be logical. The order and content of the didactic, laboratory, clinical, and field internship must be sequential and build on the content and skills developed in the previous units/modules/components. That is why the field internship should occur ***after*** all medical content and clinical experiences are completed: the field internship should provide 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: not just the chapters from the text book, but a true lesson plan that the instructor develops using multiple resources to facilitate learning. The student has the text book: the instructor should bring additional insights and resources to the topic and that information must be 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/internship sites are like gold and once you acquire them, cherish and nurture the relationships. The objective is to find resources with: personnel and preceptors committed to teaching; adequate volume and types of patients and procedures to provide the opportunity to develop competency; and locations that are convenient for program faculty to supervise the learning experience. Other variables contribute to a quality experience, such as the number and types of students from other programs. Investigate non-traditional resources for assessment experiences such as child day care centers, nursing homes, clinics,

and other unique environments. There must be a 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. Agreements should be reviewed and renewed and have a defined expiration date and not remain open ended.

Student Assessment: Things You *Must Do*

The number of times an individual performs a procedure does not determine competency – we all get that. But without the ability to keep our 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. You may use the recommended minimums from the 1998 D.O.T curricula or your program may set a different standard. However, you should be able to defend the minimums chosen and not because that number is low enough to be attainable! Whatever the number you choose, once a minimum has been set, all students **must** reach each minimum requirement. Minimum numbers may be revisited periodically and changes made based on evaluation of student competency. However, this should only occur after completion of a student cohort. The Advisory Committee, representing your communities of interest, should participate in the decisions you make based on local resources. Also be aware that the program must include the following pediatric age categories in the minimum requirements and tracking: neonate, infant, child, and adolescent. Careful tracking and documentation is required with ongoing assessment of progress toward the minimums, and opportunities for additional experience as necessary. Remember, the software or system you use does not do the tracking – humans do. So whether you relegate the tracking to the students or to the staff, the process requires frequent staff review to determine if students are meeting the required minimums then taking appropriate action.

Testing cognitive information is easy: right? Well, it may be easy to download someone's test bank or use the materials from the publisher, but do the questions test the material you covered and are appropriate to your learners? Are the questions appropriately written? Is there a clearly correct answer and are the distracters plausible? Commercial examination questions may be attractive but will likely need to be modified for your program. On the other hand, composing your own questions is often much more difficult than we imagine. 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, all exams must be evaluated for reliability and validity.

Program Assessment

It is easy to become complacent and lax in evaluating our programs. Status quo becomes the norm. If we were doing well yesterday, why wouldn't we be doing well today? Most of us recognize that the 'medicine' in EMS changes but do we respond rapidly to the changes with revised and updated curricula? And do we recognize that the *education* process itself changes and evolves? We assess our students/learners frequently: quizzes, exams, skill evaluations, clinical evaluations, field evaluations, and other tools. But we also need to evaluate our

program 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 summarized into the Resource Matrix. 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 or SLOT analysis can also be a useful tool. In this method stakeholders and staff identify the program strengths (S), weaknesses or limitations (W or L), opportunities (O), and threats (T). The resulting lists, (frequently structured as a chart with four quadrants), provides 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.

Document Activities

Students are told "If you didn't document it you didn't do it." Paramedic programs must subscribe to the same dictum. Develop a mechanism to document the assessments, evaluations, discussions, and the various changes you implement. Date all documents with the original development date and, at a minimum, the latest revision. With all program changes, ask the question: "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, the 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: summative written exam, summative final practical exam; skill attainment; capstone field internship evaluation, and any other mechanisms such as final oral examination or other 'gatekeeper' events.

RESOURCES

CoAEMSP provides a variety of resources to assist a program with new or continuing accreditation so become thoroughly familiar with the CoAEMSP web page at www.coaemsp.org. Also, it is advisable to check on a regular basis for changes, updates, and new tools. Some of the more recent resources that have been added include:

1. *Sample Initial Self Study*
2. *Sample Course Syllabus*
3. *Sample Appendices*

4. *Sample Executive Analysis*
5. *Sample Site Visit Report*
6. *Getting Started: An Action Plan*

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 are well on your way to a better program. And evaluate issues as *structural/foundational*; *process*; or *detail* specific and develop the appropriate plan.

For more information or assistance in the accreditation or reaccreditation process visit www.coaemsp.org or contact the Executive Director at 214-703-8445. Help is just a phone call away!