

Student Minimum Competency (SMC) Recommendations Q&A

October 15, 2021

The Facilitators



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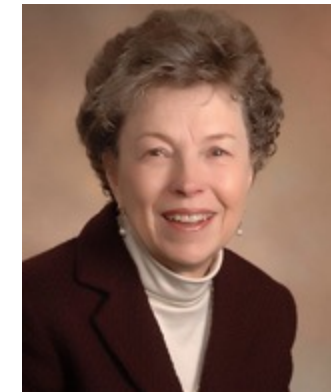
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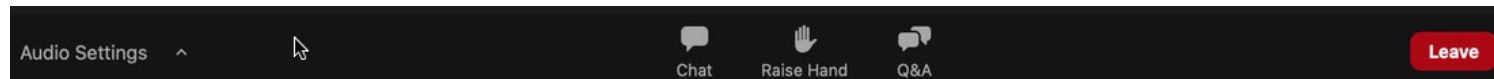
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Ways to Participate

Have a question? Type it in the **Question & Answer** window:

1. Open the Q&A window.
2. Type your question into the Q&A box. Click **Send**.
3. The host will reply back either via text in the Q&A window or will answer your question live.



Have a Best Practice? Type it in the **Chat** window

1. Open the **Chat** window.
2. Type your best practice. Tap Enter on keyboard.



Poll – Attendees...

- Dean
- Program Director
- Medical Director
- Clinical Coordinator
- Lead Instructor
- Faculty
- Other



Poll – Years of EMS Education experience...

- Less than 1 year
- 1-2 years
- 3-4 years
- 5-8 years
- 9-12 years
- More than 12 years



Credible education
through accreditation

Webinar

**Student Minimum
Competency (SMC) Matrix
Recommendations by
CoAEMSP effective
January 1, 2023**

Sep. 29, 2021

**Student Minimum Competency
(SMC) Matrix Recommendations by
CoAEMSP effective January 1, 2023**

✓ Recorded September 28, 2021



How does the new SMC affect the status of the National Registry Paramedic Portfolio?



Vendor update...

Table 1				Table 2										
Ages				Pathology or Complaint (* Simulation Permitted)										
(Only Report Successful Attempts)				(Only Report Successful Attempts)										
Minimum Number Recommended ==>	Pediatrics (Newborn to 18 years)	Adult (19 to 64 years)	Geriatric (65 and older)	Minimum Number Recommended ==>	Trauma	Psychiatric/ Behavioral	Obstetric delivery w/ normal newborn care and/or complicated obstetric delivery	Distressed neonate (birth to 30 days)	Cardiac pathology or complaint	Cardiac arrest	Cardiac dysrhythmia	Medical neurologic pathology or complaint	Respiratory pathology or complaint	Other medical conditions or complaints
	15	30	9		9	6	2*	2*	6	1*	6	4	4	6
Program Required Minimum Numbers ==>				Program Required Minimum Numbers ==>										
Graduate Name(s) ↓														
1														
2														
3														
4														
5														
6														



Table 1 - Ages

I'm concerned that getting into NICU isn't going to be possible to see sick kids. (Neonate). Could this be simulation? I'm speaking specifically about Table 1 (Min. Exposure). I see where in Table 2 simulation is allowed.

Table 1 Column 2 I see you are talking about Clinical but would simulation count for Neonates? Does simulation count at all for these columns?

Can Table 1 Column 1 be covered in lab, as they are learning? Then move into tracking Column 2 in the clinical or field?

Am I understanding that a thorough assessment and management plan would not count unless there is also a skill in Column 1 of Table 1?

Where did the 19 years of age for adult threshold come from? This is not in alignment with many field protocols in our area with respect to which patient is treated as adult or pediatric.

The discrepancies of pediatric ages are really confusing. AHA states signs of pubescence, most trauma criteria have pediatrics are <16, legality is <18, and now CoA says <19. Why?

Table 2 – Pathology/Complaint

If we are doing a simulation, does the student have to be the team leader to count these or if they are part of the team can we count them?

Are there no recommendations for assessments and skills performance during didactic?

At some point... pretty please.... Perhaps clarifying that using a human (live) person in a simulation is not a "Live encounter" as defined in the new SMC? (Do I have this nuance right?)

What is the difference between Cardiac Pathologies/Complaints and Cardiac Dysrhythmias?

The verbiage in the OB category is vague... Does it mean ONLY deliveries or complications, or any OB patient?

Table 3 - Skills

Will this change if new skills are added to the scope of practice?

Currently, I am organizing my lab for the medic 2nd and 3rd semester. For lab/field requirements, I find it close to impossible to perform the following: 12 summative pediatric intubations; 12 summative cardioversions; 12 summative pacing; and 12 summative defibrillations. A summative scenario is a full scenario, or they run the call in the field. The skills I mentioned are rare for them to perform in the field, therefore, I must have the lab cover it.

If we run a code, and during that one code we have the student cardiovert three times does that count as three summative evaluations or just one per code?

I have been unsuccessful in attaining these in most students and have had to plan for the students to come in on other days during their last semester when they do their 360 hours of field experience.

How are these performed by programs for all their students? I find those particular skills too high after they have already been performed in skills and formative formats.



What is the purpose of the information gathering as it relates to reporting the success rates for IV and other two skills? What is that information going to be used for in the future?

Why are we measuring success rates if there are no minimums?

Is there a success rate that CoA is looking for? It used to be 80%, but not listed on this matrix?

Is there going to be a minimum success rate required at some point for the 3 skills?

What makes an “unsuccessful” IV bolus medication? Wrong drug calculation? Wrong rate of administration? Wrong amount drawn up? Wrong drug given? Contraindicated drug given? Given at the wrong time for the scenario? IV and ET are clear
- IV bolus isn't as clear cut.

Column 2 - Can the patient be a human cadaver -
fresh tissue?

Table 4 – Field Experience/Capstone Field Internship

If we do not have our students completing a "field experience", where are we getting the 30 contacts on Table 4? Our students go right from didactic to clinic to capstone.

How will the CoAEMSP expect us to differentiate field experience from capstone?

How do you distinguish formative vs capstone? Our capstone has always been in the field. The reality is many of the nurses or doctors in the hospital don't give our students much of their time, so most of the clinical requirements are really "formative". Our students aren't getting a chance to "lead" in the hospital.

Are students able to start capstone while still in the didactic phase?

Table 5 – EMT Skills Competency

We teach our own students EMT, yet CoAEMSP still requires us to retest them on all of these skills prior to the start of clinical. I have asked this on several occasions and have received the same answer; we must put them through each skill and scenario. Is this change only effective after January 2023, or can we stop doing this now to gain back that time for other course items?

As a state regulator agency, I am not sure using the example of an individual holding a valid NREMT or state licensure is a sign of being competent in basic skills. An example would be the person who took the certifying exam 2 years ago but has not performed skills/procedure since then. I would agree at the time of the exam the individual showed competency.

Summary Tracking



Will this auto populate in the commercial tracking software available in the marketplace?

How are "justifications," for numbers that fall below recommendations, quantified as acceptable or not during review by CoAEMSP staff?

Do we have to complete an SMC on each student or one for each cohort?

Miscellaneous



I know you say it is recommended and not required; however, if I must fill out paperwork because it's less than the recommended then it really is required even though we can change the recommendations.

As a Program Director, with the approval of the Medical Director and the Advisory Committee; may we implement the new Student Competency Matrix before January 2023 and will CoAEMSP and NREMT accept them?

Can there be a partial implementation of the new SMC? We want to start the new SMC for our 2022-2023 class. If our vendor is not ready, may we track clinical the old way and skills the new way?



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**Contact Us /
Staff Members**



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