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HOMELESS PATIENTS AND EMS:
An Example for Needing Affective Education in EMS
by William J. Leggio, Jr., EdD, NRP
and Michael G. Miller, EdD, NRP, RN

REVIEW: 2017 FISDAP RESEARCH SUMMIT
by C. Jill Oblak, MA, MBA, NRP

PLAGIARISM 101
by Jay Scott, BS, NREMT-P and CAPCE Board of Directors

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WHAT’S INSIDE

PAGE 3  NAEMSE NEWS

PAGE 4  Membership Spotlight
by NAEMSE Staff

PAGE 5  Review of 2017 Fisdap Research Summit
by C. Jill Oblak, MA, MBA, NRP

PAGE 6  Leadership
by Dan Batsie, NREMT-P

PAGE 9  DOMAIN³

PAGE 15  Additional NAEMSE News & Updates

PAGE 17  Plagirism 101
by Jay Scott, BS, NREMT-P and CAPCE Board of Directors

PAGE 20  NAEMSE Position Paper:
Accreditation of Paramedic Program
Revised Standards and Guidelines

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www.naemse.org  | Educator Update  | 2
The ISimulate Scholarship Award Winner is: Jenn Wass Oese!

Congratulations to Jenn Oese, the ISimulate/NAEMSE Scholarship Winner! Jenn is an Interim Clinical Practice Supervisor for the Summit County Ambulance in Littleton, Colorado. This is what Jenn had to say: “I need to tell you how much this means to me personally — I have followed in the footsteps of a fellow Field Training Instructor, Bob Mosbaugh, who passed away in 2010 of ALS after a long career in EMS and EMS education, and I feel like this is a perfect way to honor him and his legacy in recognition of the intention of the scholarship.

Thank you so much for that opportunity.”

Corporate Partner ISimulate and NAEMSE are very excited to have the opportunity to award this scholarship to Jenn, who will receive airfare, hotel accommodation, and the Instructor Course 1 registration cost! Thank you to everyone who applied for the ISimulate/NAEMSE memorial scholarship!

The Importance of Participation in a NAEMSE Committee

Your Board of Directors and the NAEMSE office staff work very hard on your behalf, but what truly makes NAEMSE your organization are the committees made up of members like you. All year long, committees meet in teleconference to work on important NAEMSE projects and initiatives. For example, the upcoming Symposium’s presenters are selected based on the diligent reviews done by members of the Program Committee. The Education Committee provides guidance and development of NAEMSE’s much-sought-after educational programs. Our Research Committee works to promote research to support evidence-based practices, and our Recognition Committee seeks to acknowledge our fellow educators outstanding achievements. Our newest committee, Cultural Competency, exists to make sure NAEMSE is meeting its Inclusive core value as well as ensuring that NAEMSE programs and materials promote a multi-cultural focus. For a full list of, click here to visit the NAEMSE Committees page on our website.

Do any of those sound interesting? Are you planning to attend the Symposium in Washington, DC this August? Once a year you have the opportunity to meet in person with these committees and their chairs and to directly participate in the work of the Association. We hope you’ll take advantage of this opportunity and join us for the annual Committee Meet and Greet scheduled for Thursday, August 10, 2017 at 4:45 p.m. The event is scheduled to last only 30 minutes so it’s a quick opportunity to see what your committees are working on and how you can be a part of it.

For more information, please visit naemse.org
In addition, I am also an instructor in both EMT and paramedic classes for Suffolk County, New York.

**Hardest Job Aspect?**
The time to cover all the material necessary for a detailed education far outweighs the amount of time that is allocated.

**Most Rewarding Job Aspect?**
Watching students grasp concepts that originally were foreign to them, and become compassionate providers.

**Why Did You Join NAEMSE?**
I wanted to be a part of an organization with a common goal of creating the best education for all EMS students.

**NAEMSE Activities/Participation**
Co-Chair of the Education Committee

**Personal Hobbies**
I love to play as much golf as possible, however being a dad is the most important thing in my life... And is more fun than I could have imagined.

**Who Would Play You In a Movie?**
I would have to say Kevin James!

**What is Your Refrigerator Never Without?**
Crystal Light Iced Tea! I also wish that I was never without bacon, but I have to be good.
Review of 2017 Fisdap Research Summit

by C. Jill Oblak, MA, MBA, NRP

I was thrilled to be selected for this year’s NAEMSE scholarship to attend the Fisdap Research Summit in Minneapolis, MN. (Insert obligatory joke about traveling to Minnesota in February here!) I had previously heard good things about the summit, but wasn’t sure what exactly happened there or what to expect. After my experience, I would enthusiastically attend again and would suggest anyone with an interest in EMS research or education to do so as well.

When I arrived at my hotel there was a nice “swag bag” to welcome me with some healthy snacks and a colorful Fisdap scarf (think “Where’s Waldo?”) which made it easy to identify other attendees. I went to the evening pizza reception and made some new friends – and ran into a colleague from my area who was also a first-time attendee. Everyone was friendly and welcoming as we watched the Falcons lose the Super Bowl. One participant was clearly from New England - she was particularly happy about the Patriots win.

The next morning, we headed to the conference site and got into our research groups. My group was analyzing data in relation to the Paramedic Psychomotor Competency Portfolio requirement by evaluating whether there was a relationship between the number and type of Simulated Team Leads (STLs) conducted by students in lab during paramedic programs and students’ performance on Field Team Leads (FTLs), attainment of capstone team lead competency, or performance on cognitive exam scores. Each research group had a dedicated Fisdap programmer and a psychometrician to pull data from Fisdap records and run statistical tests appropriate for each analysis.

After we worked on our projects, we all reconvened and reported on findings. Some of the topics explored by other groups included: pain management medication administration for OB patients; the effect of program sequencing on student outcomes; whether the number of cardiac calls a student experienced influenced scores on unit and comprehensive exams; whether there was a relationship between ROSC and airway type; use of CPAP versus intubation for respiratory distress patients; and a mixed methods case study of a flipped classroom delivery of OB lessons in an EMT class.

I was impressed with the levels of enthusiasm, rigor, and sophisticated research methodology used by all the participants, as well as the energy, organization, and hospitality of the Fisdap and Jones and Bartlett staff. The research summit was a great experience both personally and professionally and the two days flew by. By delving into the data available from so many EMS education programs we can better design effective educational experiences to help our students and help patients. Working and networking with such an esteemed group of colleagues was so rewarding, and I am grateful to NAEMSE for the support and opportunity to attend. I hope to become a regular participant and to see you there next year!
Leadership
by Dan Batsie, EMT-P

Leadership is a subject that is receiving much attention in EMS education as of late. Our lesson plans have finally responded to the long known, but seldom taught, notion that teams perform better than individuals in a crisis. EMS students everywhere are “training like they fight,” communicating in “closed loops,” and our novice scene commanders are experiencing the simulated trials and tribulations of managing teams in stress filled scenarios. While students are imprinting these lessons of leadership in the classroom, our EMS agencies are recognizing a leadership crisis of a much different proportion. Services around the country, particularly the small, rural and volunteer services, have found leadership a commodity that is particularly hard to come by. Although there are many sound operational and clinical team leaders, not nearly enough qualified and truly prepared candidates have emerged to replace the visionaries that have brought our profession to where it is today. We can all agree that our profession needs strong leaders, but is EMS education responding to this problem or contributing to it? Is the model of leadership introduced in our classroom focused on creating innovators and visionaries or is “leadership” just one more phrase in the lexicon of EMS students, stated in vain repetition by candidates hoping to successfully complete a scenario station?

Lee Burns, Director of New York EMS, has an interesting EMS leadership litmus test. She asks, when teaching her leadership class, how many people went into EMS with the idea that someday they would lead a nonprofit corporation with a million-dollar budget. The most commonly response from the room is silence. This exercise effectively points to the leadership gap plaguing our profession. Unfortunately, the pattern is well established. Far too often ambulance services fail not because of falling call volumes or changing economic climates, but rather because of a lack of preparation among their senior administrative teams. It’s not hard to imagine considering where most EMS leaders come from. Our leadership ranks are filled with well-intended medical professionals with very little training to prepare them for management roles. Chiefs around the country are promoted not because of any particular leadership aptitude or training, but rather because they show up for work and because they are good at clinical vocations that have very little to do with managing people.

EMS education has contributed to the problem by an error of omission. For years, we have been passive players with regard to developing our replacements. While we use terms like “team leader” and “teamwork,” we have done actually very little to formalize leadership into our lesson plans and made minimal efforts to foster the development of leaders in our classes. While no one will doubt the value of teaching operational teamwork, if our leadership lessons stop at “closed loop communications,” then we have missed important opportunities to address an urgent need.

Of course, the burden of creating qualified leaders cannot be shouldered singularly by EMS education. We need an initiative addressed at all levels of our system that includes initial education, mentoring, formal leadership tracts and post-secondary education. However, if indeed the quest for better prepared leaders is a burden that all of us will bear, our educators should define early how we can contribute to the solution and take proactive steps to join the fight.

In initial licensure classes we delicately balance the quest for entry level competency against the need to instill the lessons of lifelong learning. There is assuredly no time to address the full breadth of EMS leadership or create fully prepared leaders in the small number of contact hours we can offer our students. However, with forethought and planning, we can instill foundational lessons, beyond the operational scenarios, that will allow students to see in themselves the path toward broader leadership roles. Perhaps no student will emerge from an EMT class fully prepared to take the role of chief of a department, but if that student leaves the class understanding fundamental leadership lessons such as task cohesion, delegation and team communication, haven’t we laid the framework for future success?

The core concepts of leadership are founded in the team dynamic used every day in the scenario model. When students execute the basic concepts of team leader and team member, they begin to understand the universal relationships fundamental to leadership regardless of how large the organization. Concepts such as team leader affect, task delegation, and communication teach future managers vital interpersonal relationship skills.
If aligned properly, the mandatory competencies required of the novice student negotiating scenarios in the lab can establish and reinforce the same core concepts we value in our leaders. In addition to the buzz words of crisis response, facilitators should play close attention to interpersonal communication, decisiveness, and delegation as they are all traits universally valued in management and are skills that are imminently teachable. Educators, as partners in a larger professional initiative, can introduce those core concepts, add context to foundational lessons and celebrate the achievements as leadership potential is identified and developed. Most importantly however we as educators can create a culture where the traits of effective leaders are valued and appreciated.

In the United States Marine Corps every new recruit is provided a book entitled Leading Marines. This book is distributed in the earliest weeks of basic training and is intended to initiate the core lessons of how every Marine must prepare to one day to replace the Marines that lead him now. This book includes lessons on tactics, but more importantly it describes the characteristics of leadership that are universal whether you are leading a team of five people or five hundred. Our strategy for developing leaders should borrow a page from the Marine Corps and begin initiating these core concepts in our earliest classes. Our core affective lessons, in addition to teaching patient dignity respect and courtesy, should include core lessons on emotional intelligence, relationship building, and mentoring. These lessons cannot wait for the future continuing education classes. We must seize the earliest opportunities to imprint the value of these concepts.

Scenarios and high fidelity simulation are valuable tools to formulate leadership skills. We should rely heavily on their capacity to add context to the otherwise philosophical theories. However, leadership lessons can be found in abundant supply outside of the simulation lab. Opportunities exist every day in the classroom to impress upon students the core values of leadership. When teams of students are formed to approach tasks as simple as knowledge quests, group projects or even classroom clean up, leaders emerge. If educators can utilize these everyday situations and hold students accountable to demonstrate key leadership principles then the foundations for future leaders have been laid. Assigning measurable tasks and demanding accountability formulates the leader-follower relationship and providing opportunities for students to seek and take responsibilities rewards the manager behaviors we are desperately trying to foster.

If well-prepared individuals are what we truly need, our profession should build a system where the development of leaders is a priority. Our classes should not only teach leadership, but also recognize and develop quality leadership traits in our new initiates. To do this, educators must create an environment where leadership is universally appreciated and create classrooms where assertiveness is not a characteristic to be valued in men and suppressed in women. The fact that women represent less than 5% of all corporate executive officer roles in America’s largest companies should indicate that we have sorely and sadly missed a widely untapped resource. Isn’t it time for EMS to elevate our well prepared and willing young professionals regardless of their gender? We frankly cannot afford to discriminate. Like with many other profound cultural shifts in EMS, our classes can nurture a message that will eventually spread to the larger profession.

In addition to the formal lesson plans that are developed, educators should recognize the vital role they play in modeling the leadership traits we wish to develop in our students. If we expect our leaders to possess accountability, then our educators should be open to formalized feedback and offer regular opportunities for students to express ownership of their education. If we value goal setting, task cohesion and communication, then these phrases should be written into every syllabus and highlighted at every course orientation. Educators should openly discuss desired outcomes, publish goals, not only for their classes, but for themselves and demonstrate regular and open communication as to the status of these objectives. These lessons will be modeled in the leaders of tomorrow and will be intractable once imprinted.

Mentoring is also a powerful tool when it comes to creating leaders and should not be underestimated. Certainly, the one-on-one mentoring that occurs between educator and student is incredibly valuable and a wide range of leadership concepts can be facilitated through that relationship. However, we should not forget opportunities for students to mentor one another. Whether it be through academic tutoring, laboratory partnerships or even simple orientation of new candidates, using peer to peer interaction benefits both parties equally and offers profound leadership development benefits.
LEADERSHIP

The students being mentored benefit from the transfer of knowledge from the more experienced to the novice, while the students doing the mentoring learn invaluable lessons on servant leadership. Not only do the student mentors improve their own learning in the classic “see one-do one-teach one” model, but they also develop confidence and self-efficacy from the role of being a mentor. Mentoring is also an opportunity to develop quiet leadership skills for those candidates less inclined to perform in front of the larger class. Different students emerge as leaders at different paces and no opportunity should be missed to allow them to flourish.

Finally, our EMS educators should be taught the art of leadership as well. Far too often it is assumed that because a person is an EMS educator they must also be a good leader. This assuredly is not always the case. But where will our educators receive these essential leadership lessons? Where will they turn to understand these very important concepts? If developing new leaders is indeed the priority, then our current leaders must make time and put forth the effort to produce the desired result. Our leaders of today must participate in educational opportunities and help prepare those who will emerge next.

Moving forward we must integrate leadership lessons into continuing education of instructors and provide mentoring opportunities for them as well.

Where the profession of emergency medical services goes from here is largely in our own hands. We have made great strides, but face challenges we can only overcome by creativity, innovation and inspiration. How prepared our leaders of tomorrow will be is largely of function of the work we do today and we must remember that this cannot be a passive process. Great leaders are not born that way. They aren’t delivered to us by miraculous intervention. Leaders can and should be taught. Although initial licensure classes are only a small part of a larger initiative, the tone set in these entry points is essential for facilitating the later evolution of leaders. True greatness comes from great people and if true greatness is what we desire, we must lay the framework now. Developing tomorrow’s EMS leaders is everyone’s responsibility.

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www.naemse.org  Educator Update  8
Homeless Patients & EMS: An Example for Needing Affective Education in EMS
by: William J. Leggio, Jr., EdD, NRP and Michael G. Miller, EdD, NRP, RN

When is it a Team Lead?
Variations on a Theme: What, Why, When, Where, How (many), Who
by: Patricia L. Tritt, RN, MA - CoAEMSP

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MISSION STATEMENT:
To inspire and promote excellence in EMS education and lifelong learning within the global community.
Recent reports found in 2015 the following of all homeless people: 63% are individuals, 37% were in families, 15% are chronically homeless, 2% were in chronically homeless families, 8% are veterans, 6.5% are unaccompanied youth and children, and only 30.7% are sheltered compared to 69.3% being unsheltered.  

Health Challenges in the Homeless Population

Many predictive factors for accessing ED care have been identified in homeless populations, which include: older age, previous hospital admissions and ED visits, inadequate mental health care, poor health status, and HIV infection. Additionally, substance abuse is a complicated predictive factor as it can both contribute to and be worsened by homelessness as well as impact the other factors as well. A study reported nearly half of homeless patients considered themselves as having a drug or alcohol problem in the past year.

For EMS providers, there are lifestyle and other special considerations to remember when assessing and caring for homeless patients beyond just the seasonal environmental exposures. These patients may be difficult to access due to the variety of materials used for shelter, and multiple layers of clothing makes physical examination challenging. Lack of being able to eat well-balanced meals and limited access to clean water impacts their ability to eat healthy. Homeless patients also have compromised dental and oral hygiene, often because of toiletries being unavailable to them. The rate of sexually transmitted disease is higher in the homeless population compared to the general population, especially for homeless females as they are more likely to engage in prostitution and “survival sex” in exchange for food, drugs, or shelter. The pregnancy rate for homeless females is doubled of the general population. The HIV infection rate is higher amongst homeless populations compared to the general population due to limited access to sexual protection, prostitution, and intravenous drug use.

There is a need for situational awareness when interacting with these patients as mental illness tends to be part of the patient’s medical history. Depending on the patient’s abused substance(s), there may be additional safety concerns as well as side effects from the substance contributing to their emergency. It is imperative to look beyond the initial assessment and patient presentation when treating a homeless individual as they may have other medical conditions, both known and unknown to them. Significant medical emergencies, such as stroke and myocardial infarcts, can occur in patients regardless of socioeconomic status. A homeless patient’s lifestyle, lack of accessing healthcare, and potential substance abuse can all contribute to or increase cardiac and stroke risks.
Respiratory conditions, such as emphysema, pneumonia, and COPD are also common, especially if a smoker, in the homeless population. Gastrointestinal (GI) and hepatic conditions can also be commonly seen, such as a GI bleed, pancreatitis, ulcers, cirrhosis, and hepatitis in the homeless population. Hepatitis C has specifically been suggested as one diagnosable marker to identify homeless patients at risk for frequent ED use.

The frequency of head injuries in the homeless population occur at twenty times greater than the general population. Head injuries in the homeless patient population are commonly complicated by alcoholism, resulting in an increased risk for cerebral hemorrhage. Injuries from falls and violence are often common mechanisms of traumatic injuries. In a previous study, nearly 60% of homeless individuals reported being a victim of a crime.

Providing Compassionate Care to Homeless Patients

A theory was challenged that increasing homeless patient satisfaction scores would encourage these patients to make more return visits. This theory was proved wrong as providing compassionate care to selected homeless patients accessing care at an inner-city emergency department did improve satisfaction scores but did not cause an increase in short-term repeat visits. The study reported a decrease in repeat visits following compassionate management and provided one explanation that patients simply tend to return frequently until they are satisfied with their treatment.

Discussion

Though the trend of homelessness in America appears to be decreasing, it is reported to only be by less than 2 individuals per 10,000 persons. A significant homeless population still exists with a significant rate of turnover as only 17% are chronically homeless individuals or families. No information was discovered to identify a decreasing reliance on EDs as primary means of accessing healthcare and high frequency of repeat visits by homeless patients. However, competing behaviors between homeless patients being treated rudely, feeling like they were not heard, and consequently seeking care again for the same problem seems to correlate to a demonstrated decrease in repeat visits from increases in homeless patient satisfaction scores after receiving compassionate care.

This conflicting treatment of homeless individuals highlights a need for affective domain education and student evaluation regarding professional interaction with homeless patients.

The literature only discussed ED staff treating homeless patients rudely, but it also discussed dynamics of mistrust between homeless individuals towards EMS providers and first responders. Logically, this mistrust most likely has roots in how EMS providers and first responders treat and interact with homeless patients.

The affective domain of learning is generally described as being focused on feelings and attitudes exhibited in behaviors. EMS providers utilize this domain on a daily basis and when interacting with each of their patients. Affective and cognitive domains should not be viewed separately, instead should be viewed together as critical thinking is thought to depend on both domains. The interdependence of affective and cognitive domains for critical thinking is important to understand in EMS education as these items are essential for clinical performance, understanding patients holistically, and awareness. Furthermore, the affective domain serves in internalization of values and learned behaviors following application of comprehension and experiences.

As EMS education continues to embrace simulated education, specifically with the importance of integrated out-of-hospital scenarios, there is a need to include scenarios involving homeless patients. Homeless patients present with a known variety of medical problems, traumatic injuries, and special considerations. Moreover, because there are known affective deficits when treating homeless patients, there are affective domain considerations to involve as well. Therefore, simulated homeless patients could serve as a single simulated patient that can be realistically designed to challenge and evaluate a student’s cognitive and affective domains; as well as their psychomotor skills.

Conclusion

Homeless patients generally tend to be more dependent upon EDs, EMS, and first responders than the general population. However, it has been discussed how these patients are treated rudely, are not listened to, and their concerns not fully addressed. Issues of mistrust between homeless patients and public safety mechanisms exists. These unfortunate realities are most likely adding to their dependence on EDs and EMS. In contrast, compassionate care has been shown to decrease this dependence. This supports the need for simulated encounters with homeless patients during EMS education to develop the cognitive and affective domains to treat these patients compassionately. All patient types, such as geriatric and pediatric, present with their own challenges and special considerations. Homeless patients are not an exception to this and ought to be considered their own patient type with challenges and special considerations. It is important to understand the challenges and considerations for all patients, but is also important to ultimately treat all patients compassionately.
When Is It a Team Lead?
Variations on a Theme: What, Why, When, Where, How (many), Who

By: Patricia L. Tritt, RN, MA, Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP)

The Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) continues to explore the nuances of ‘when it is a team lead’ and ‘how may team leads do we need?’. Both may appear to have simple answers but clearly do not.

The What: team leads are a capstone experience. Capstone refers to a culminating student experience in which students apply the concepts that they have learned to solve real-life problems. It is an opportunity for students to demonstrate that they have achieved the terminal goals for learning established by their educational program and to demonstrate entry level competency in the profession. The CoAEMSP Policies and Procedures Manual define a capstone experience as: “Activities occurring toward the end of the educational process to allow students to develop and practice high-level decision making by integrating and applying their Paramedic learning.”

The primary goal of a Paramedic program is to produce a competent, entry level practitioner in all three domains: cognitive, psychomotor, and affective. So the question becomes: how is this determined? Certainly final, summative, cumulative evaluations/examinations are key.

These usually occur in the classroom environment. But the field environment, and how the student performs in the real-time patient care setting, is critical. The final crucible is the evaluation of the Paramedic student responding to all types of patient complaints under the supervision of a carefully selected, seasoned Paramedic preceptor. During the team lead phase the preceptor is the one who deems the student capable of leading the EMS responder team in the assessment and management of a variety of patient types/complaints/calls. The preceptor observes and evaluates, and only offers advice or suggestions if crucial errors or omissions occur. The student is ‘in charge’ and demonstrates the skills, knowledge, and abilities to manage any call to which the unit is dispatched.

Does the EMS call have to be considered as ALS to count as a team lead? Opinions vary, but probably ALS classification is not necessary for all team leads, and indeed can be contrived by adding an IV start or obtaining an EKG. Responses that are considered BLS often involve assessing and managing patients with complex medical problems and can be rich learning experiences. A variety of ALS calls are obviously important but team leads should not exclude those situations that required a detailed assessment and application of critical thinking skills. However, transfer calls do not typically meet the assessment and management criteria: for example transfers from a nursing home to a hospital or from one acute care facility to another. There are exceptions, but the primary goal of the field internship is response in a 911 system.

In summary, the What and Why: team leads should be a capstone experience and should provide the field preceptor and the program faculty the opportunity to adequately evaluate the competency of the soon-to-be graduate.
When can this capstone experience occur? The CoAEMSP recognizes that some programs institute field rides early in the academic schedule and thereby allow for both field experience and field internship. In the healthcare environment, internships typically occur after the completion of the initial course of study. Internships provide the opportunity to apply the knowledge and skills acquired. The CAAHEP Standards and Guidelines for the profession include in the Guideline language regarding the curriculum, “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.” The capstone team leads occur during this internship period.

To differentiate the two types of field experiences, the CoAEMSP Policies and Procedures Manual provides the following definitions:

**Field experience:** planned, scheduled, educational student time spent on an advanced life support (ALS) unit, which may include observation and skill development, but which does not include team leading and does not contribute to the CoAEMSP definition of field internship.

**Field internship:** planned, scheduled, educational student time on an advanced life support (ALS) unit to develop and evaluate team leading skills. The primary purpose of the field internship is a capstone experience managing the Paramedic level decision-making associated with prehospital patients.

These definitions can be found at: [http://coaemsp.org/Documents/PoliciesProcedures.pdf](http://coaemsp.org/Documents/PoliciesProcedures.pdf)

There next element is Where? Team leads must occur in a 911 response system. As mentioned previously, while transfer calls may be handled by any agency, only non-transfer calls may generally be precepted as team leads.

A word on the When of sequencing: it is tempting to initiate field rides early in the curriculum for a variety of reasons. For example, it may be easier to schedule the required hours or students desire to get to the goal environment early (‘the field’). However, never lose sight of the goal of the field internship: it is a culmination of all the learning that has proceeded: classroom/didactic, laboratory, and the hospital/other clinical environments. The student should possess the skills, knowledge, and abilities to address any clinical issue presented. This includes all types of complaints, conditions, or age groups. So for example, all of the pediatric, obstetric, and geriatric portions of the curriculum should be complete prior to team leads that are documented as part of the minimum required number.

How should team leads occur? Students and preceptors must be provided with specific objectives. Students should be assigned to a single (best case scenario) or a limited number of preceptors to provide an optimal environment for growth and evaluation. Evaluation tools should be specific and measurable.

And finally Who should precept team leads? Ideally, preceptors should be selected by joint agreement of the Program Director or Clinical Coordinator and the EMS agency. Preceptors should meet some level of field experience (for example one, two, or more years), be willing to precept students, and must receive training/orientation by the Paramedic program.

A frequent question is also ‘how many team leads are acceptable?’ Programs are left to determine the minimum number of successful team leads required based on: input from the various communities of interest (for example the Program Advisory Committee, employers, the program Medical Director, and the faculty; evaluation of student competencies; and other programmatic assessment of successful outcomes.) The number, however, cannot be based on ‘that’s all we can get.’

Information from one of the commercially available tracking systems provides a valuable insight to current practices. For the most recent three year period, FISDAP reported on 12,548 completed paramedic students. The mean number of team leads was 54 and the median number was 51. Tracking/documentation often involves self-reported/student entered data and of course the definition/parameters established by each program. However, this information provides a useful view into current practice.

Various research supports these recommendations. Below is a summary of abstracts published in the FISDAP Research Summit findings.

**The Effect of Paramedic Student Internship Experience on Performance on the National Registry of Emergency Medical Technicians Exam; 2006.** Salzmann, Dillingham, Kobersteen, Kaye, Page.

Conclusions: The number of ALS runs students completed was the strongest predictor of passing the NRE-W. Paramedic programs may want to evaluate the number of ALS runs and total patient contacts their students are currently completing.

Conclusions: Working with fewer preceptors increases the encounters paramedic student leads. Paramedic programs may want to consider having their students establish a relationship with one primary preceptor.


Conclusions: There is a relationship between paramedic student internship experience and a students’ critical thinking ability. More research is needed to determine whether this relationship is affected by other variables such as student motivation and educational methods.

When is a Paramedic Student a Competent Team Leader? 2012. Widmeier, Washick, Dinsch, Cage, Mayne, Asche.

Conclusions: the standard of success in 18 out of the last 20 attempted team leads is a reliable predictor of continued student competency. Students may need more than the previously recommended 50 attempts to reach competency so programs should provide for sufficient team leadership opportunities.

CoAEMSP will continue to analyze tracking and student success data and other metrics associated with student and program success as program standards are reviewed and revised to achieve the primary program goal: to prepare competent entry level paramedics in all three domains: cognitive, psychomotor, and affective.

Reprinting Information
Interested in reprinting this article? If so, please contact Brandon Ciampaglia via e-mail at brandon.ciampaglia@naemse.org or by phone at (412) 343-4775 ext. 29
RESULTS OF 2017 NAEMSE BOARD OF DIRECTORS VOTING

The National Association of EMS Educators (NAEMSE) 2017 Board of Directors and Governance Committee has concluded the ballot count of the 2017 elections, and we are pleased to announce the election results:

Newly elected Board Members are:

Jill Oblak, MA, MBA, NRP, Pittsburgh, PA

Mr. John Todaro, EMS Faculty/BS, NRP, RN, TNS, NCEE, St. Petersburg, FL

Mr. Daniel Carlascio, NRP, Lindenhurst, IL

Mr. Bryan Ericson, M.Ed., RN, NRP, LP, Hurst, TX

All elected candidates will take office at the 2017 annual educational symposium general membership meeting on Friday August 11, 2017.

The NAEMSE Board of Directors congratulates the new directors, and extends its sincere appreciation to all the candidates for their willingness to serve the Association in this leadership capacity.

The NAEMSE Board of Directors also wishes to thank the members who served on the 2017 Governance Committee:

- Dr. John Karduck, M.D.
- Mr. Michael Dunaway, BS, NREMT-P, CCP, NCEE
- Dr. Walt Stoy, PhD., EMT-P
- Mr. Nathan Stanaway, BS, NRP
- Connie Mattera, MS, RN, EMT-P, TNS

THRIVE FOR 5: MEMBERSHIP DRIVE 2017

NAEMSE needs your help! Thrive for 5 is our new membership drive and we’d love for you to participate. Our driving force behind it is:

Invite - someone who is not a member of NAEMSE to join the association.

Involve - new members in the association. Help them join a committee, guide them through the symposium, and inspire them to continue their education through instructor courses.

Invest - in EMS education. By inviting and involving new members, you are supporting the growth of NAEMSE and investing in EMS education.

The Goal: 500 new members by August 5th, 2017 (Symposium) and 5,000 total members before Chris Nollette leaves office, as your President in 2018.

We Need You!

Help us reach this goal by encouraging your colleagues to become a member and you will be entered into a raffle for a chance to win a 3 year paid membership to NAEMSE!

Details

For every five (5) new members you refer you will be entered into a raffle to receive a three (3) year paid membership fee. One winner will be chosen.

How?

Have referrals join NAEMSE via our website registration page: https://naemse.site-ym.com/general/register_member_type.asp?

- Or -

Download a hard-copy of our MEMBERSHIP APP (https://c.ymcdn.com/sites/naemse.site-ym.com/resource/resmgr/Application_2015.pdf). When filling out the application, please have referrals select “Colleague” and write the referrer’s name in the space provided.

When?

The deadline for referrals is August 5th, 2017. We will announce the winner the week of August 21st, 2017.

If you have any questions, please contact: matt@naemse.org
Call for Abstracts

Using science to advance EMS practice

Submit your research for the 1st Annual INTERNATIONAL SCIENTIFIC EMS SYMPOSIUM, to be held at EMS World Expo 2017, facilitated by the Prehospital Care Research Forum at UCLA.

Do you have EMS research to disseminate? Are you a student or EMS provider who is new to research and looking for feedback from leaders in the field? We are looking to develop the next generation of EMS researchers who will be part of the evolution of EMS.

Researchers who submit the top clinical abstracts receive a complimentary registration to EMS World Expo in Las Vegas, October 16—20, will be invited to present their abstracts at the International Scientific Symposium and will have their abstracts published by EMS World.

Visit prehospitalcare.org to learn more and submit your abstract by August 31, 2017. Questions? E-mail pcrf@mednet.ucla.edu.

PCRF SALUTES OUR SUPPORTING ORGANIZATIONS:
Plagiarism 101
By: Jay Scott, BS, NREMT-P and CAPCE Board of Directors

Words of wisdom from a father to his son, legendary UCLA basketball coach John Wooden: “Don’t lie, don’t cheat, and don’t steal.” Plagiarism is all three, lying, cheating and stealing. The person who plagiarizes risks legal, moral, ethical, financial, professional, and personal misery. Those inclined to take the path of least resistance by using someone else’s work, without citing it, may reap rewards initially, but those rewards quickly vanish if the offender is caught. For those poor souls the consequences can be devastating. Perhaps the Scottish poet Sir Walter Scott said it best: “Oh what a tangled web we weave when first we practice to deceive.”

The Commission on Accreditation for Pre-Hospital Continuing Education (CAPCE) was formed to improve and standardize the delivery of continuing education (CE) for practicing EMS providers. CAPCE is a professional organization that holds dear the concepts of professionalism and originality of work. In this article, CAPCE provides answers to the following questions:

• What is plagiarism?
• What are the consequences of plagiarism?
• What is the CAPCE policy toward plagiarism?
• How do you cite another person’s work?
• What must be cited?

One of the goals of CAPCE is to ensure originality in continuing educational programs. This document serves as both a policy statement and a tutorial.

What is Plagiarism?

Plagiarism is defined as the “wrongful appropriation,” “close imitation,” or “purloining and publication” of another Author’s “language, thoughts, ideas, or expressions,” and the representation of them as one’s own original work.

Essentially, plagiarism is the act of using someone else’s work and passing it off as your own, or more simply put, stealing someone else’s work and lying about it afterward. According to plagiarism.org., the following are considered plagiarism:

• Turning in someone else’s work as your own.
• Copying words or ideas from someone else without giving credit.
• Failing to put a quotation in quotation marks.
• Giving incorrect information about the source of a quotation.
• Changing words but copying the sentence structure of a source without giving credit.
• Copying so many words or ideas from a source that it makes up the majority of your work, whether you give credit or not.

The act of plagiarism is of particular interest to the CAPCE Board of Directors because it is a means of gaining CAPCE accreditation through, “Fraud in course content during the procurement of any CAPCE accreditation of a continuing education activity.” Continuing education programs that contain written text, slide presentations, and videos must adhere to the CAPCE accreditation guidelines.

Plagiarism Case Study:

A CAPCE reviewer is reading an application for accreditation for a written article on respiratory system anatomy. The initial paragraph is written poorly, full of technical, grammatical and spelling errors. The body of the article is written at a very high level. It is technically perfect and full of expert analysis. The closing paragraph is written just like the first, full of grammatical errors.

The CAPCE reviewer concluded that this article was written by 2 different people. He performed a google scholar search and found that the body of the article was copied and pasted from a text book chapter on respiratory anatomy.

CAPCE rejected the application for accreditation and reported the incident to the applicant. The author of the article was subsequently released from her employment.

What are the Consequences of Plagiarism?

Sarah Smith, a writer from Politico.com, detailed 10 instances of famous people caught taking liberty from another person’s work. Here are four notable examples:

Joe Biden - The vice president was forced to withdraw from the 1988 presidential race over allegations of plagiarism. Many parts of Biden’s speeches on the trail, as Maureen Dowd of the New York Times reported, were lifted from the unsuccessful run of British politician Neil Kinnock of the Labor Party against Prime Minister Margaret Thatcher. Revelations followed that Biden took parts of his speeches from Robert Kennedy, JFK and Hubert Humphrey.

Doris Kearns Goodwin - Goodwin, a former Lyndon Johnson aide, was accused of using phrases from other books in her own, including the popular “The Fitzgerald’s and the Kennedys”. Goodwin claimed it was accidental and withdrew unsold copies of the book to correct it.

Mike Barnicle - Ex-Boston Globe columnist Mike Barnicle resigned in 1998 after questions were raised as to whether he made up people in a 1995 column.
An alternative Boston newspaper also reported that he took portions of a 1986 column from a book published in 1961. Barnicle’s resignation — which he said was “the best thing for the paper” — ended a 25-year career at the Globe.

Fareed Zakaria - Journalist Fareed Zakaria was promptly suspended from Time Magazine and CNN in 2012 when he used a paragraph from a New Yorker article for a column he wrote in Time. The organizations investigated his work and reinstated him. He called what happened “a terrible mistake” in an interview with the New York Times.6

It is true that in all of the above cases the offenders were able to salvage their careers. However, their credibility and reputation suffered. In addition, those who choose to plagiarize risk both criminal and civil litigation. This may, in extreme cases, include fines and jail time. More importantly, creators of educational programs risk their credibility, respectability, and integrity - values that can never be negotiated. CAPCE values integrity in education above all else and will not accept compromise.

Plagiarism Case Study:

A CAPCE reviewer is assigned to an application for accreditation. The application consists of eight narrated power point presentations. The presentations were well prepared, full of interesting pictures and professional anecdotes. The reviewer recognized the work from a popular website written and maintained by a well-known EMS author and medical director. He opened both web pages and compared them to one another. He found that the applicant had taken all of the works from the original author, changed the authors name and placed them on his own web page before applying for CAPCE accreditation.

The application was rejected and CAPCE notified the original author of the issue. The original author took legal action against the applicant.

What is the CAPCE Policy Toward Plagiarism?

CAPCE has no legal obligation to detect or report plagiarism; however, CAPCE will check CAPCE-accredited courses and accreditation applications for originality and proper citation/referencing practices. Any article, course, presentation or other EMS CE offering that is submitted to CAPCE for accreditation is expected to be original work. CAPCE requires that all non-original work be properly cited.

CAPCE will reject any application for accreditation that is not original, is found to be plagiarized and/or is not properly cited or referenced.

CAPCE maintains the right to withdraw accreditation from any work that is found to be not original, to not properly cited/referenced, or is plagiarized. Work that is not original but is properly cited to the original author is acceptable. CAPCE is not liable for acts of plagiarism discovered or not discovered by its review process.

Upon recognizing potential plagiarism in a CAPCE application, the CAPCE reviewer shall:

• Document his/her findings.
• Record as much information as possible.
• Contact the CAPCE office and report the incident.2

How Do You Properly Cite Another Person’s Work?

There are three simple guidelines regarding citing someone else’s work:

1. Cite within the written text with the footnote number:

   Words of wisdom from a father to his son, legendary UCLA basketball coach John Wooden: “Don’t lie, don’t cheat, and don’t steal.”

2. Place the footnoted citation at the bottom of the page or presentation slide:


3. Place all footnotes at the end of the document.

There are various formats to properly cite a source, depending on the type of work cited (i.e., book, journal article, website, etc.). Below are the CAPCE accepted styles:


PLAGIARISM 101


Personal Communication: Avoid reference to personal communications, but when necessary, include the person’s name, his or her title, month, and year of contact. A letter granting permission to publish from the person providing the information must be included at the time of submission.2

What Must be Cited?

Whether or not to cite is an important decision for any writer. But it’s certainly a simple one. When in doubt, cite it. Avoid the temptation of pretending something is your idea, when it’s not. The wise writer errs on the side of caution. The following list, compiled by the Penn State e-Education Institute, represents those items that are no-brainers – they must be properly cited:

1. Anything someone else said or wrote. Avoid trying to paraphrase what someone said in your own words. By properly citing, you lend authority to your work. Adding the words of experts (e.g. opinions, quotations, theories, etc.) raises the bar of credibility for your project.

2. Any statistical data that you did not arrive at through original research. This also includes another author’s methods or results.

3. Any photography or artwork taken from another source. In many cases, you will have to obtain permission to use copyrighted materials.

Items that do not require citing include anything considered to be common knowledge or facts that are found in many sources. These are considered to be in the “public domain” and, often, cannot be attributed to any one person.7

Best Practices

Legitimate EMS continuing education agencies pride themselves on the originality of their work. They refuse to compromise on this standard and, by doing so, maintain their credibility. They remain ever vigilant in this process. They know that a plagiarism charge comes at high cost to the organization. It’s a simple matter of doing the right thing. To this end, their efforts include:

- Making the overall decision to cite whenever necessary and whenever in doubt.
- Citing within written text with a footnote number.
- Supplying footnotes in the accepted style either at the bottom of a page or slide or at the end of the document or slide presentation.
- Using an online plagiarism checker for all educational materials.

Truthfulness, credibility, integrity – these things don’t come automatically or without a cost. The price is eternal vigilance. The best programs pay it willingly. Because of their commitment students learn more, patients receive better care, and EMS continues to mature into a bona fide allied health care field. “Don’t lie, don’t cheat, and don’t steal.”1 Because everything you do after words comes under scrutiny.

2. CAPCE Standards and Requirements (S&R), Appendix D: CAPCE Complaint Review and Discipline Policy, Reasons for Review, Denial, Suspension, Revocation or Fine, Item C.
Position Paper
National Association of EMS Educators (NAEMSE)

**Topic: Accreditation of Paramedic Program revised Standards and Guidelines**

Walt Stoy Ph.D. and Connie J. Mattera, MS, RN, EMT-P for the National Association of EMS Educators, Strategic Relations & Advocacy Committee

Standards and Guidelines history and revised criteria content reviewed and confirmed as accurate by CoAEMSP.

**NAEMSE Position Statement**

NAEMSE supports the most recent changes identified in the Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions. For nearly four decades, CoAEMSP has been the conduit for EMS educational programs to obtain Commission on Accreditation of Allied Health Education Programs (CAAHEP) accreditation for their paramedic programs. These most recent additions continue to position EMS educational programs to strive for and achieve best practice; evidence-based models of excellence in program planning, delivery, and evaluation.

The original Standards document was published in 1978. Since that time, it has been revised four times. The fourth and most recent modification took place in 2015. In 12 areas of the document there are 18 additional criteria. It should be noted that items were also deleted from the document. This position paper only speaks to the additional elements.

It is important to note CoAEMSP has created and recently published a document comparing the 2005 to the 2015 CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions. There are very few changes in the 10 years since the last revisions. These modifications are changes to assist in the clarity of the information.

**Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions**

**Sponsorship – Sponsoring Institution**

For a distance education program, the location of program is the mailing address of the sponsor.

*Self-explicating and NAEMSE supports this guideline modification.*

**Program Goals - Program Goals and Outcomes**

The Advisory Committee should have significant representation and input from non-program personnel. Advisory committee meetings may include participation by synchronous electronic means.

*NAEMSE position: We support this guideline provision. It is vitally important to assure that an unbiased relationship is established and maintained with the Advisory Committee. The committee should have strong representation from individuals with multi-disciplinary backgrounds from outside of the program to give the broadest and most informed scope of input and direction. The committee should use technology to facilitate remote access to meetings whenever necessary to allow full participation within the extent of existing resources.*

*NAEMSE strongly supports the desire for inclusion and participation of Committee members in providing direction, support and oversight to ensure that the program achieves the goals and objectives as they are identified and approved. Particular input and feedback should be sought from current and former students of the program as representatives to the Advisory Committee.*
Program Goals - Minimum Expectations
Nothing in this Standard restricts programs from formulating goals beyond entry-level competence.

**NAEMSE Position:** We support this guideline provision and encourage all EMS educational programs to formulate goals that not only meet, but exceed (as appropriate) those specified in the various National Educational Standard documents based on local needs and planning. Paramedic program personnel should work with the Advisory Committee to assure that goals and objectives are defined for all three domains of learning and individual student achievement is measured, trended, and documented.

Resources – Personnel – Program Director – Qualifications
Program Directors should have a minimum of a Master's degree.

**NAEMSE Position:** We support this guideline requirement as it mirrors the standards of other allied health professions and will advance the careers and improve the preparedness of EMS educators to lead and direct effective educational programs. Current Program Directors who do not yet have graduate degrees should start exploring advanced study options that will best enhance their ability to competently perform the current and anticipated future duties required of their position. The preferred focus of study for a Paramedic Program Director may include, but not be limited to a Master’s degree in EMS, Education, Business Administration, or Health Services Administration with program content in Administration and Supervision; Curriculum and Instruction; Teaching, Learning, and Assessment; Technology in Education; etc.

For most programs, the program director should be a full-time position.

**NAEMSE Position:** We support this guideline provision. This requirement should allow Program Directors (PD) sufficient time to ensure that a quality educational program is provided and student achievement is appropriately measured, supported, and documented. The PD should be positioned to devote time to professional development and mentoring to increase the likelihood of their students’ success. In addition, all program directors (full time or part time) should seek to engage as fully as possible in the broader EMS education, research, and publications, communities of interest at the local, regional, state, national, and/or international levels based on their interests, abilities, and resources.

Resources – Personnel – Medical Director – Responsibilities
Corrective measures should occur in the cases of adverse outcomes, failing academic performance, and disciplinary action.

**NAEMSE Position:** We support this guideline requirement. The Medical Director and Program Director should be fully informed if an unplanned adverse event or violation of student or program policy occurs and be engaged in defining plans for service recovery, student and/or faculty remediation, corrective coaching, risk abatement, disciplinary action, or dismissal from the program. The Medical Director should work in conjunction with the Program Director and service(s) medical directors to assure that all standards are met.

The Medical Director interaction should be in a variety of settings, such as lecture, laboratory, clinical, field internship. Interaction may be by synchronous electronic methods.

**NAEMSE position:** We support this guideline requirement with the following caveat: The proportion of time devoted to each of these areas need not be equal; however, effective engagement should occur in all aspects of the program. Technology to assist with this work should be explored, vetted, and provided to the program as resources allow and reports of outcomes provided to CoAEMSP so others would benefit.
Resources – Personnel – Associate Medical Director – Qualifications

For a distance education program, the location of program is the mailing address of the sponsor

Self-explicating and NAEMSE supports this guideline modification. NAEMSE also supports the position of CoAEMSP regarding the Assistant Medical Director who is required for the out of state locations when students are engaged if the program Medical Director is not licensed in that state.

Resources – Personnel – Faculty / Instructional Staff – Qualifications

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.

**NAEMSE Position: We support this guideline provision with the following caveats:** The availability of additional instructional personnel is most likely dependent on the size of the program and resources in terms of staffing and funding. At this time it would appear that no clear data is available to definitively determine ideal ratios of faculty members and students. This is an opportunity to gather and analyze data from current programs. It can be argued that nursing is not a higher level of education depending on Associate or Baccalaureate degree programs, but rather different in terms of scope of practice. Programs should be required to inform CoAEMSP of what “higher levels of professional training” are being considered. Finally, data on staffing plans, key performance indicators, scope of work, and cost of personnel should be acquired, aggregated and disseminated to those positioned to analyze and report the findings to determine the targeted number of FTEs for the benefit of growth in the program.

Resources – Personnel – Lead Instructor – Responsibilities

The Lead Instructor duties may include teaching paramedic or AEMT course(s) and/or assisting in coordination of the didactic, lab, clinical and/or field internship instruction.

**NAEMSE Position: We support this guideline provision with the following caveat:** Paramedic lead instructors must be qualified and competent to perform their duties as assigned. Ideally they should have a history of effective teaching experience within a Paramedic or AEMT course. However, other instructional experience and documented competence in appropriate healthcare-related domains would most likely meet this requirement as long as the individual was able to demonstrate full knowledge of the national EMS Education Standards and content. Some programs have multiple educational offerings resulting in multiple lead instructors. It is most likely program dependent whether coordination of didactic, lab, clinical and field components occurs at various levels throughout all the programs currently accredited and local justification of staffing plans and personnel duties should be considered.

Resources – Personnel – Lead Instructor – Qualifications

Lead Instructors should have a Bachelor’s degree.

**NAEMSE Position: We support this guideline provision.** The degree should be from a reputable nationally accredited institution. Ideally, the focus of study should be a degree that includes major coursework in adult education principles. NAEMSE recognizes that the intent is to assure those in these positions have a higher level of education than those they are instructing. However, just like in all areas of higher education, the specific degrees that would meet this requirement will most likely vary and should be determined as acceptable by the local program.
The Lead Instructor role may also include providing leadership for course coordination and supervision of adjunct faculty/instructors.

**NAEMSE Position: We support this guideline provision.** The Program’s organization chart should clearly represent lines of authority and spans of influence and control. This should also be addressed in the hierarchy of classroom management.

The program director may serve as the lead instructor.

**NAEMSE Position: We support this guideline provision.** In many smaller programs, and in the case of temporary staff openings in any program, one person assuming dual roles is customary and acceptable. As EMS Program expansion occurs into broader scopes of (specialty) practice or perhaps multiple and/or higher degrees, the division of these duties assigned to multiple leaders will become increasingly important to achieve program goals.

**Resources – Curriculum**

Further pre-requisites and/or co-requisites should be required to address competencies in basic health sciences (Anatomy and Physiology) and in basic academic skills (English and Mathematics).

**NAEMSE Position: We support this guideline provision.** As these are determined and implemented, they should be shared with CoAEMSP to be aggregated into a common database. This information should be shared with all appropriate organizations working with CoAEMSP to evaluate their ability to suggest changes to the curricula as well as pre-requisites and/or co-requisites. In time, a more comprehensive statement of required (pre-requisites and/or co-requisites) classes to take part in paramedic education could be provided to the EMS community.

AEMT is based on competency, but may be typically 150-250 hours beyond EMT, which is 150-190 hours, and may be taught separately or combined.

**NAEMSE has no position or comment regarding this guideline matter.**

**Student and Graduate Evaluation/Assessment – Outcomes – Outcomes Assessment**

“Positive placement” means that the graduate is employed full or part-time in the profession or in a related field; or continuing his/her education; or serving in the military. A related field is one in which the individual is using cognitive, psychomotor, and affective competencies acquired in the educational program.

**NAEMSE Position: We support this guideline provision.** This can be achieved predominantly by looking at two aspects to begin the process – those employed in EMS or a related healthcare field and those that are not employed in healthcare. A major limitation to this requirement is the difficulty in getting former graduates to respond to post-class surveys or to inform programs as to their employment status. However, pursuing this data is desirable. For those not “directly” employed in the EMS profession, a stratified list of areas to which graduates appear to migrate might be established. NAEMSE desires to know more regarding the career paths of EMS Program graduates to better prepare them during their tenure as students.

“National credentialing examinations” are those accredited by the Institute for Credentialing Excellence. Self-explicating and NAEMSE supports this modification.

**Fair Practices – Publications and Disclosure**

The sponsor should develop a suitable means of communicating to the communities of interest the achievement of students/graduates (e.g., through a website or electronic or printed documents).
NAMESE Position: We support this standard provision. In addition, this data must be shared with individuals and organizations as requested. It must be reviewed for accuracy and kept current.

Summary

Regarding all the areas modified above, it is of utmost importance that data must be collected, collated, evaluated and disseminated relative to all aspects of EMS programming. As EMS education continues to evolve, we must be positioned to re-design and re-develop standards, content, methods, evaluation strategies, and communication tools based upon evidence and industry best practice models. We support this approach to the current and future processes that shall be required for Program accreditation.

NAEMSE is highly supportive of the efforts of CoAEMSP and CAAHEP to assure quality education for paramedic students. We look forward to continued success in sustaining standards that position the EMS domain to achieve value-based, quality care for the populations we serve.

Again, NAEMSE recognizes that these modifications are “housekeeping” changes provided to assist in the clarification of the guidelines. NAEMSE supports these modifications and looks forward to additional insight concerning how national programmatic accreditation shall continue to assist in affording a quality educational experience to those in paramedic educational programming across the nation.

About the authors:

Walt Alan Stoy, Ph.D., EMT-P Professor and Director, Emergency Medicine Program, School of Health and Rehabilitation Sciences, University of Pittsburgh

Get those walkin’ shoes ready and head out to Washington, DC this summer! We have a special offer exclusively for our NAEMSE members: **Save $100.00 off Registration!** You may register directly online @ https://www.naemse.org. Online registration is managed directly by NAEMSE, so please contact us with any issues or concerns. As a service to our NAEMSE members we will also have onsite registration counters.

Did you know that DC is the capital of free! Have you thought about bringing the family with you to the symposium? There are plenty of “FREE” attractions that you and the family can enjoy before the start of symposium, after hours and at the end of the symposium. The Omni Shoreham hotel is located near the Washington National Zoo, and across the street from the Woodley Park Station, Red Metro Line.

Washington, DC offers 100 FREE attractions and activities for everyone. Few cities in the world provide the same access to incredible museums, one-of-a-kind events and incredible displays as Washington, DC. Let us know if we can help! A DC map will be provided in your registration bag. This year, Co-Chairs Jim Dinsch and Bryan Ericson, have planned a program that will have a wide sample of national and international EMS education professionals who will be converging on our nation’s capital to unite in the purpose of advancing the practice of EMS and EMS education nationally and internationally! This year the topics range from cognitive learning theory, evaluation of the affective learning domain, social aspects of the EMS classroom and many other best practices for your EMS classroom. No matter what level you teach, you will find many great topics and dynamic speakers to help you improve your personal practice! You will also note the some of the speakers and topics you have come to expect from the NREMT, CoAEMSP, NHTSA and CAPCE and many more!

**We look forward to seeing you in Washington, DC with those walkin’ shoes on!**
A Blast From The Past...

Thank you for the Memories!