In-station program Evolution

1972 NWC was the first Resource Hospital in Illinois, launching the Mobile Intensive Care Unit) (MICU program with nine EMS provider agencies, less than 100 paramedics, and quickly three Associate hospitals: ABMC, RES, and HFMC. (GSH and HEMC joined in 1980).

70s Period of rapid growth of the System. Entry level classes held at NCH. Continuing education offered during monthly evening classes that rotated among the System Hospitals and an annual seminar held off site at a larger venue. Annually, paramedics came to NCH for a comprehensive written and practical exam.

Advantages: Efficient; large numbers of students at each class, only 3 classes/month could be done by hospital personnel with existing resources. Great opportunity for networking and socializing among paramedics and EMTs.

Disadvantages: Paramedic readiness to learn; large overtime expenses for agencies; large numbers that did not meet CE requirements on time and need for back up plans; and difficulty assuming a level of knowledge due to inconsistent attendance at classes. Class content and quality was inconsistent depending on site and faculty.

1981 Chief Larry Pairitz (MPFD) approached NCH asking to pilot a change in approach to CE. He asked for an educator to come to his agency on a monthly basis for all three shifts. Goals of the program were to see if providing CE on duty in a smaller group environment would increase learning, attendance and compliance with CE hour requirements, improve test scores, and decrease his costs for overtime. Connie Mattera conducted the pilot, and all program goals were met with great feedback. He saved 58% on his costs for the year.

When these results were reported to the rest of the chiefs, they enthusiastically asked to make this a System-wide standard. We collaboratively created the “In-station” program. It was determined that the chiefs would support the cost of hiring one “Rocket nurse” to coordinate the program, create the CE classes and personally teach at least 15-19 classes/month. The remaining classes were taught by the EMSCs at the Associate Hospitals (ABMC, HFMC, GSH, HEMC, RES) supplemented by EMS Educators for the EMT and EMT-P programs when their classes were not in session.

The agencies asked to divide the program budget into fixed (billed annually) and variable (per visit) line items to fairly distribute costs among larger and smaller agencies. NCH worked with the chiefs to determine the timing of the program fiscal year (May 1 to April 30) and their billing cycles. It was agreed that the program should be budget neutral to NCH and that the System would bring the annual budget proposals to the chiefs’ for their review and approval.

1982 In-station program launched with 47 visits per month and Marti Gindville (Payne) as the first IS Coordinator. Classes for each agency were held on standing dates/times per their request.

80s- It rapidly grew in size as the System expanded provider agencies and numbers of EMTs and paramedics. By the mid-80s it required hiring an additional PT IS educator to help cover all of the classes. Oher IS educators of that era: Barb Schretter Kopecky & Wendy Seleen. Diana Neubecker was hired in 1988 when Wendy left. Annual testing transitioned away from the hospital to be part of the in-station program.

Late 90s The System Education Committee had its origins as a task force that first convened in 1997 to address the (C-2) Continuing Education policy and provide feedback on the In-station program. It was officially chartered as a standing System Committee in January 1999.

Early 2000s As the System continued to gain Provider Agencies, the program grew and the centrally hired Instation educators grew to 2.5 FTE to help cover 105 classes/month.

The next evolution was proposed again by MPFD. Wendy Seleen had left the System to be an EMSC in Elgin. When Marge Kostick retired from HFMC, Wendy returned to the System as Marge’s successor. When HFMC was transitioning from an acute care hospital, Mike Figolah approached NCH asking if they hired Wendy, whether she could conduct their IS classes as she had been a System educator and Associate hospital EMSC. The proposal was approved and thus the Peer IV educator was born.

2007 Last fundamental review of program conducted by a multi-disciplinary committee including full support and approval of the Chiefs.. See attached recommendation document.

CURRENT STATE: 9-16-16

In-station Continuing education (CE) Program

- The goal of our CE program is to present offerings that enable System to members to maintain and expand professional knowledge and skill competencies with novel content that is tied to standards.
- At the present time, we conduct over 95 classes/month; 10 months per year. A full explanation of CE requirements is specified in EMS Policy C2: Continuing Education.
- All lesson plans, educational reference materials, handouts, AV aids, consumable med-surg supplies; post-test banks, post-tests, and class credit questions are prepared by the Resource Hospital IS educators. Handouts are printed by NCH. Class materials are distributed to Hospital EMSCs/ educators and Peer IV educators who each assist in teaching at least seven classes per month at no cost to the program. Several teach far in excess of the minimum requirements. The remaining classes are conducted by the Resource Hospital IS educators and the Administrative Director as time allows.
- The **budget** for the program continues to be prepared by the Administrative Director and approved annually by the chiefs/administrators. It continues to be divided into fixed and variable costs paid by all EMS agencies, with each line item listed and supported so all System members know exactly what they are approving. These revenues support the salary and benefits of the 2.2 FTE IS educators and 33% of the part-time EMS secretary. It does not cover the salaries of all the other educators who conduct classes.

Standards to be met:

From current NWC EMSS Strategic plan:

The **Continuing Education program** meets contemporary needs of the educators and learners and operates within its budgetary plan. Cognitive competency continues to be measured through valid and reliable post-tests and modular exams.

Evidence of achievement:

1. The CE program operates within the budgetary plan.
2. CE billing is processed quarterly and tracking of accounts receivable is accomplished by the NCH accounting office.
3. Class scheduling mutually accommodates the needs providers and educators.
4. PBPI findings are one of the drivers of CE content.
5. CE educators conduct the classes as designed by Resource Hospital educators and apply principles of adult learning theory when teaching.
6. Exams are blueprinted to educational objectives. Content validity is confirmed by peer review. Exam construct validity is confirmed by the EMS Administrative Director and EMS MD. Exam reliability is measured by item analysis and comparison of scores across all EMS agencies.

From Paramedic *Continuing Education* National Guidelines

(The U.S. DOT, in cooperation with the U.S. Department of Health and Human Services Public Health Services and the Health Resources & Human Services Administration, Maternal and Child Health Bureau, published the Continuing Education National Guidelines)

- Supported by NHTSA, these guidelines replace the 1985 EMT-P and EMT-I Refresher Courses. The are part of a series of courses making up a national EMS training program consistent with the recommendations of the *National EMS Education and Practice Blueprint*, the *EMT and Paramedic Practice Analysis*, and the *EMS Agenda for the Future*.
- Advocates that CE should move toward a quality assurance model that identifies individual and system areas for improvement and incorporates these topics into the CE program.
- A major emphasis of this document is to transition EMS education and continuing education from strictly an hours-based to a **competency-based approach**. They give rationale for the necessity of recertification/ relicensure including the rapid expansion and perpetually changing nature of medical knowledge and skills and professional accountability. Trends dictate that providers "prove" their ongoing competence.
- The model suggested in this document addresses two primary areas of concern: (1) competence (measure of minimum proficiency of EMS providers' knowledge and skills) and (2) ongoing

education which is designed to assure that the EMS provider obtain "new" knowledge and skills as well as maintain prior knowledge and skills. Underlying their model is the assumption that credentialing agencies expand that number of types of mechanisms through which a provider can demonstrate competence.

- They recommend that the assessment process used in relicensure provide a complete picture of the EMS professional's competence in three areas:
  - Actual field performance (assessment of practice outcomes)
  - Assessment of potential to practice: Ability to respond appropriately to a wide range of patient situations including those that are important, new, or infrequently encountered. Local EMS agencies should offer structured education on topics identified though their QI program as an emerging need.
  - Assessment of professional qualities (attitudes and behaviors)
- Mechanisms for competency assurance are specified. *Competency-based education, directly toward the attainment of specific, behaviorally defined objectives requires separate tests of the attainment of each of the competencies*.
  - Needs assessment
  - Assurance of knowledge through a variety of CE and refresher programs
  - Assurance of skill proficiency through field performance evaluation, hospital clinical performance evaluations, skills workshops, and performance examinations
- The document states that EMS systems should ensure that CE helps providers keep up with the rapid changes in emergency care. Local medical directors must verify that personnel are competent in local/regional equipment, policies, and procedures. For every system change, verification of the training and implementation process must be documented.

Successful health systems exhibit four hallmarks of 'systemness'

Insight 10 from the 2015 CEO Special Sessions
Expert Insight/October 19, 2015

All of the most cohesive systems exhibited four traits.

- Clearly defined governance structures doing the right things at the right level
- Hardwired roles and responsibilities for key stakeholders
- Incentive structures that don't just support system goals but also don't encourage counterproductive behavior
- And, underneath it all, a free flow of information—not just data, but knowledge and experience—that enables smarter, quicker action

The NWC EMSS strives to meet these traits, thus we are opening up the IS program again for review.

See SWOT analysis