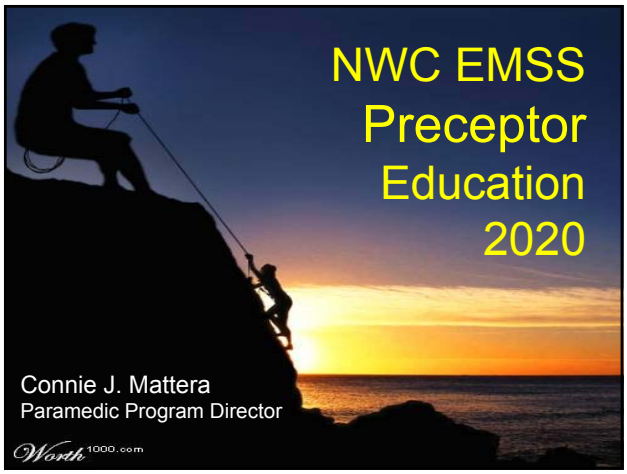



## *Introducing your new mentees!*

*"You are now our partners in … education & practice excellence!*

Northwest Community Healthcare (NCH) PARAMEDIC PROGRAM
**Squad and Agency Assignments**
**2019-2020 – Revised 2-6-20**

| Squad 1 | Squad 2 | Squad 3 | Squad 4 | Squad 5 |
|---|---|---|---|---|
| Akers, Michael AH | Dahl, Matt MP | Frisk, Patrick SCH | Acevedo, Brandon PAL | Montes, Arlen RM |
| Bosco, Benjamin MP | Dyer, Matthew SCH | Kennedy, Richard DP | Reich, Kayla BLFPD | Porter, Sean BLFPD |
| DeAvilla, Monique SCH | Hohmeier, Michael LZ | Miner, Adeline PAL | Martinelli, Mark SCH | Traxel, Bryan HE |
| DeJaynes, Jacob SCH | Hubberts, Anastasia EGV | O'Mahoney, Brian PAL | McLoughlin, Kane DP | |
| VanDuch, Jonathan PAL | Moens, Scott HE | Scott, Devin LZ | Sincox, James AH | |
| | | | Sloan, Erik SCH | |

## Content

- Environment driving change in education & practice
- Program of instruction: core classes, schedule by wks; accreditations, domains of learning; competencies
- Goals and objectives
- Adult learners and adult learning theory
- Learning contracts and outcome measures
- Methods for planning a learning experience
- Roles and responsibilities of preceptors
- Strategies for evaluating performance and giving feedback; criteria for evaluation; conflict resolution
- EMS 215: Sequencing, expectations, forms and documents

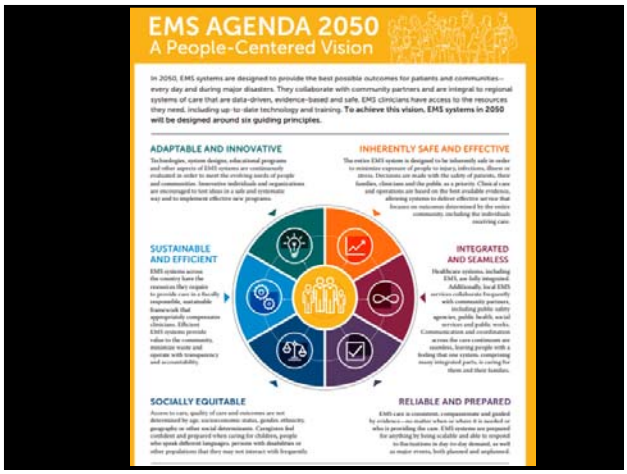
## Environment driving change in education & practice

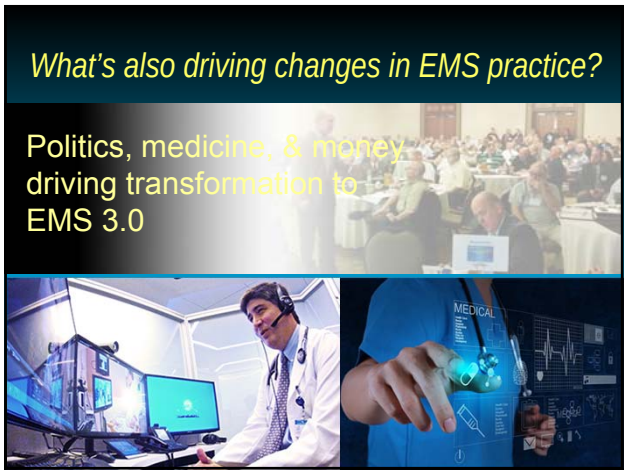
The speed of technology expansion is exponential – moving faster than ever before, replacing generations of progress in months, weeks, and days.

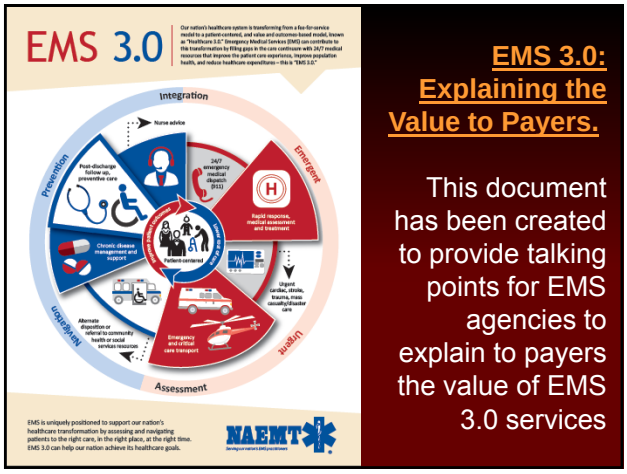
EMS must excel at adapting & change mgt.


## SHAPING A BOLD FUTURE,TOGETHER…

EMS Agenda 2050 sets the vision and 6 guiding principles for next 30 years

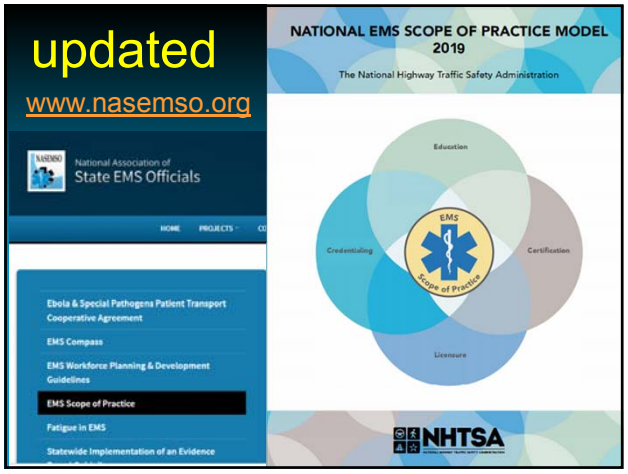


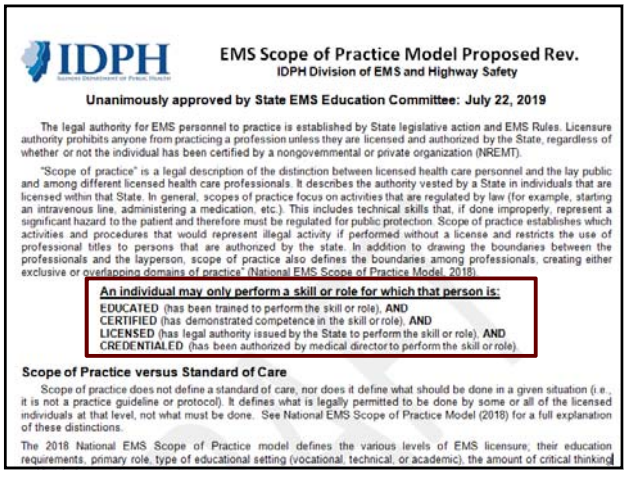




**EMS 3.0: Explaining the Value to Payers.**

This document has been created to provide talking points for EMS agencies to explain to payers the value of EMS 3.0 services



IDPH

**EMS Scope of Practice Model Proposed Rev.**
**IDPH Division of EMS and Highway Safety**

**Unanimously approved by State EMS Education Committee: July 22, 2019**

The legal authority for EMS personnel to practice is established by State legislative action and EMS Rules. Licensure authority prohibits anyone from practicing a profession unless they are licensed and authorized by the State, regardless of whether or not the individual has been certified by a nongovernmental or private organization (NREMT).

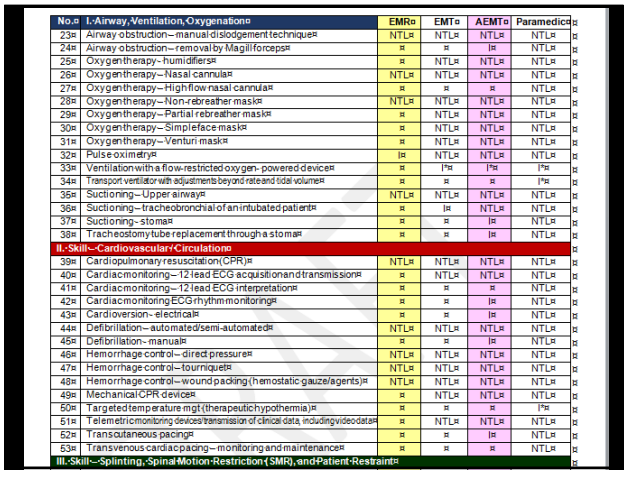
"Scope of practice" is a legal description of the distinction between licensed health care personnel and the lay public and among different licensed health care professionals. It describes the authority vested by a State in individuals that are licensed within that State. In general, scopes of practice focus on activities that are regulated by law (for example, starting an intravenous line, administering a medication, etc.). This includes technical skills that, if done improperly, represent a significant hazard to the patient and therefore must be regulated for public protection. Scope of practice establishes which activities and procedures that would represent illegal activity if performed without a license and restricts the use of professional titles to persons that are authorized by the state. In addition to drawing the boundaries between the professionals and the layperson, scope of practice also defines the boundaries among professionals, creating either exclusive or overlapping domains of practice" (National EMS Scope of Practice Model, 2019).

**An individual may only perform a skill or role for which that person is:**
**EDUCATED** (has been trained to perform the skill or role), **AND**
**CERTIFIED** (has demonstrated competence in the skill or role), **AND**
**LICENSED** (has legal authority issued by the State to perform the skill or role), **AND**
**CREDENTIALED** (has been authorized by medical director to perform the skill or role).

**Scope of Practice versus Standard of Care**

Scope of practice does not define a standard of care, nor does it define what should be done in a given situation (i.e., it is not a practice guideline or protocol). It defines what is legally permitted to be done by some or all of the licensed individuals at that level, not what must be done. See National EMS Scope of Practice Model (2019) for a full explanation of these distinctions.

The 2019 National EMS Scope of Practice model defines the various levels of EMS licensure, their education requirements, primary role, type of educational setting (vocational, technical, or academic), the amount of critical thinking



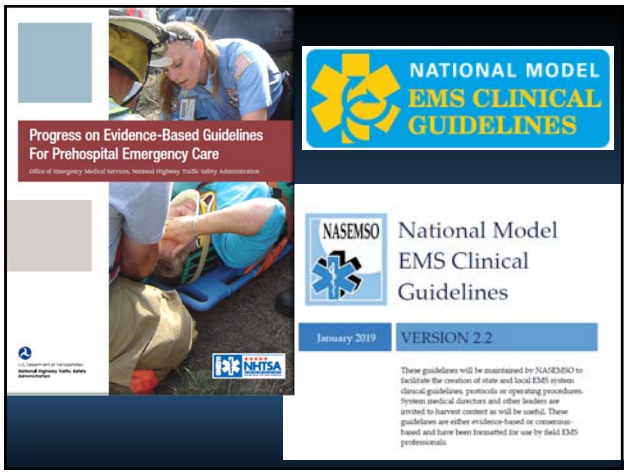
| No. | I. Airway, Ventilation, Oxygenation | EMR | EMT | AEMT | Paramedic |
|---|---|---|---|---|---|
| 23 | Airway obstruction – manual dislodgement technique | NTL | NTL | NTL | NTL |
| 24 | Airway obstruction – removal by Magill forceps | | | | NTL |
| 25 | Oxygen therapy - humidifiers | | NTL | NTL | NTL |
| 26 | Oxygen therapy – Nasal cannula | NTL | NTL | NTL | NTL |
| 27 | Oxygen therapy – High flow nasal cannula | | | | NTL |
| 28 | Oxygen therapy – Non-rebreather mask | NTL | NTL | NTL | NTL |
| 29 | Oxygen therapy – Partial rebreather mask | | NTL | NTL | NTL |
| 30 | Oxygen therapy – Simple face mask | | NTL | NTL | NTL |
| 31 | Oxygen therapy – Venturi mask | | NTL | NTL | NTL |
| 32 | Pulse oximetry | | NTL | NTL | NTL |
| 33 | Ventilation with a flow-restricted oxygen- powered device | | I* | I* | I* |
| 34 | Transport ventilator with adjustments beyond rate and tidal volume | | | | I* |
| 35 | Suctioning – Upper airway | NTL | NTL | NTL | NTL |
| 36 | Suctioning – tracheobronchial of an intubated patient | | | NTL | NTL |
| 37 | Suctioning - stoma | | | | NTL |
| 38 | Tracheostomy tube replacement through a stoma | | | | NTL |
| II. Skill – Cardiovascular Circulation | | | | | |
| 39 | Cardiopulmonary resuscitation (CPR) | NTL | NTL | NTL | NTL |
| 40 | Cardiac monitoring – 12 lead ECG acquisition and transmission | | NTL | NTL | NTL |
| 41 | Cardiac monitoring – 12 lead ECG interpretation | | | | NTL |
| 42 | Cardiac monitoring ECG rhythm monitoring | | | | NTL |
| 43 | Cardioversion - electrical | | | | NTL |
| 44 | Defibrillation – automated/semi-automated | NTL | NTL | NTL | NTL |
| 45 | Defibrillation - manual | | | | NTL |
| 46 | Hemorrhage control – direct pressure | NTL | NTL | NTL | NTL |
| 47 | Hemorrhage control – tourniquet | NTL | NTL | NTL | NTL |
| 48 | Hemorrhage control – wound packing (hemostatic gauze/agents) | NTL | NTL | NTL | NTL |
| 49 | Mechanical CPR device | | NTL | NTL | NTL |
| 50 | Targeted temperature mgt (therapeutic hypothermia) | | | | I* |
| 51 | Telemetric monitoring devices/transmission of clinical data, including video data | | NTL | NTL | NTL |
| 52 | Transcutaneous pacing | | | | NTL |
| 53 | Transvenous cardiac pacing – monitoring and maintenance | | | | NTL |
| III. Skill – Splinting, Spinal Motion Restriction (SMR), and Patient Restraint | | | | | |

Creation
Purpose
Scope

NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
EST 1972

**PROCEDURE MANUAL**

Jan. 1, 2020



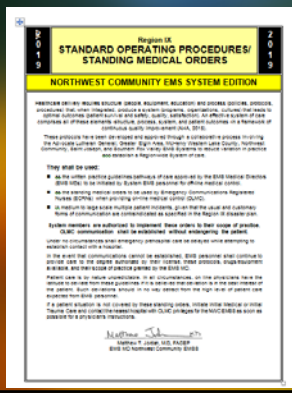

Where are the levels of patient acuity defined?

National EMS Core Content

Critical
Emergent
Lower Acuity

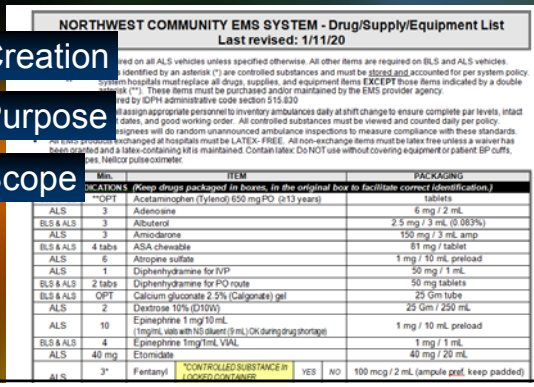
## Standard Operating Procedures (SOPs)

Creation
Purpose
Scope
Who may deviate?



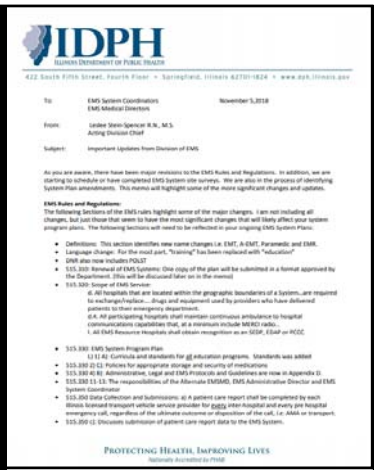

## Drug & Supply List

Creation
Purpose
Scope




| Min. | | ITEM | PACKAGING |
|---|---|---|---|
| INDICATIONS | | (Keep drugs packaged in boxes, in the original box to facilitate correct identification.) | |
| ALS | **OPT | Acetaminophen (Tylenol) 650 mg PO (≥13 years) | tablets |
| ALS | 3 | Adenosine | 6 mg / 2 mL |
| BLS & ALS | 3 | Albuterol | 2.5 mg / 3 mL (0.083%) |
| ALS | 3 | Amiodarone | 150 mg / 3 mL amp |
| BLS & ALS | 4 tabs | ASA chewable | 81 mg / tablet |
| ALS | 6 | Atropine sulfate | 1 mg / 10 mL preload |
| ALS | 1 | Diphenhydramine for IVP | 50 mg / 1 mL |
| BLS & ALS | 2 tabs | Diphenhydramine for PO route | 50 mg tablets |
| BLS & ALS | OPT | Calcium gluconate 2.5% (Calgonate) gel | 25 Gm tube |
| ALS | 2 | Dextrose 10% (D10W) | 25 Gm / 250 mL |
| ALS | 10 | Epinephrine 1 mg/10 mL (1mg/mL vials with NS diluent (9 mL) OK during drug shortage) | 1 mg / 10 mL preload |
| BLS & ALS | 4 | Epinephrine 1mg/1mL VIAL | 1 mg / 1 mL |
| ALS | 40 mg | Etomidate | 40 mg / 20 mL |
| ALS | 3* | Fentanyl *CONTROLLED SUBSTANCE in LOCKED CONTAINER YES NO | 100 mcg / 2 mL (ampule pref, keep padded) |

## New EMS Rules adopted 11-5-18 and again 4-1-19



Major Provisions Illinois EMS Education Rules & National Standards – Approved 7-22-19 - page 1

| Section | Items | Content |
|---|---|---|
| | | SUBPART D |
| 515.500 | **EMS Training Program Application/Site Code Policy and Procedure** | An EMS education program shall only be conducted by an EMS System or an academic institution under the direction of the EMS System. Oversight, quality assurance and outcome measurement for all EMS education programs shall be the responsibility of the EMS MD and the EMS System Coordinator, with cooperation of the educational institution/program and lead instructors.<br>**Source standards**<br>• National EMS Education Standards (current edition)<br>• National EMS Scope of Practice Model skills (2019)<br>• Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP)<br>• Additional course curricula required by the Department<br>**Forms**<br>• EMS Training Program Application (IDPH EMS website): http://www.dph.illinois.gov/topics-services/emergency-preparedness-response/ems/testing-Edu)<br>• See EMS Rules and/or **Site Code Submission** Checklist Rev 7-19 for attachments to each application [Appendix A]<br>**When to submit**: At least 60 days prior to start of program<br>**Where to submit**: Regional IDPH EMSC<br>Submission of repeated programs without changes – See EMS Rules<br>Changes requiring an amendment to the Training Application – See EMS Rules<br>Responsibilities of the EMS MD, EMSC, and Lead instructor: See EMS Rules |
| Integrating with National standards | | **See the National EMS Education Standards for recommendations relative to** educational facilities, student space, instructional resources, instructor preparation sources, storage space, sponsorship, programmatic approval, faculty, Medical Director oversight, hospital clinical experiences, field experience, course design, student assessment, and program evaluation for EMR, EMT, and AEMT courses. The National EMS Education Standards defer to the Committee on Accreditation for EMS Professions (CoAEMSP) standards and guidelines for paramedic courses. |
| 515.500 | **EMT Initial Education Policy and Procedure** | **Minimum required Hours**<br>• IDPH requirements<br>  ▪ 125 didactic - plus<br>  ▪ 25 clinical (minimum pt care contacts, competency evaluation/ measurement)<br>  ○ Hospital or alternate care facility<br>  ○ Field – # of minimum patient care contacts |

## National Education Standards Draft 2 out for comments now

National EMS Education Standards
DRAFT FOR PUBLIC COMMENT – Version 2.4 – 01 February 2020
For Review and Comment – Do Not Quote or Cite

| | EMR | EMT | AEMT | Paramedic |
|---|---|---|---|---|
| Preparatory | Uses simple knowledge of the EMS system, safety/well-being of the EMR, medical/legal issues at the scene of an emergency while awaiting a higher level of care. | Applies fundamental knowledge of the EMS system, safety/well-being of the EMT, medical/legal and ethical issues to the provision of emergency care. | Applies fundamental knowledge of the EMS system, safety/well-being of the AEMT, medical/legal and ethical issues to the provision of emergency care. | Integrates comprehensive knowledge of EMS system, the safety/well-being of the paramedic, and medical/legal and ethical issues which is intended to improve the health of EMS personnel, patients, and the community. |
| EMS Systems | Simple depth, simple breadth<br>• EMS systems<br>• Roles, responsibilities, and professionalism of EMS personnel<br>• Quality improvement vs. quality assurance<br>• Culture of safety / Patient safety<br>• Continuum of care | **EMR Material PLUS:**<br>Fundamental depth, foundational breadth<br>• Roles, responsibilities, and professionalism of EMS personnel<br>Simple depth, foundational breadth<br>• EMS systems<br>• Quality improvement vs. quality assurance<br>• History of EMS<br>• Culture of safety / Patient safety<br>• Systems of care, e.g., Stroke, STEMI, Trauma, Pediatrics<br>• Continuum of care | **EMT Material PLUS:**<br>Fundamental depth, foundational breadth<br>• Quality improvement vs. quality assurance<br>• Culture of safety / Patient safety<br>• Systems of care, e.g., Stroke, STEMI, Trauma, Pediatrics<br>• Continuum of care | **AEMT Material PLUS:**<br>Fundamental depth, foundational breadth<br>• History of EMS<br>Complex depth, comprehensive breadth<br>• EMS systems<br>• Roles, responsibilities, and professionalism of EMS personnel<br>• Quality improvement vs. quality assurance<br>• Culture of safety / Patient safety<br>• Systems of care, e.g., Stroke, STEMI, Trauma, Pediatrics |

## EMS Instructor Qualifications

A Template to Assist States with Implementing the EMS Education Agenda for the Future: A Systems Approach

National Association of State EMS Officials—December 2010
For more information: www.nasemso.org

## Creation – Purpose - Scope

NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
EST 1972
NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
POLICY MANUAL
2020


**Northwest Community EMS System** — **POLICY MANUAL**

| Policy Title: **PRECEPTOR: Paramedic/Prehospital RN students** | | | No. P - 1 |
|---|---|---|---|
| Board approval: 3/14/19 | Effective: 3/14/19 | Supersedes: 7/1/10 | Page: 1 of 3 |

I. **INTRODUCTION**

A. All paramedic and Prehospital RN (PHRN) students shall be directly supervised, mentored and evaluated by an approved preceptor.

B. The preceptor shall act as a resource, facilitator and guide. This individual is valued not only as a teacher but serves as a role model exemplifying the standards of excellence in the NWC EMSS. Therefore, the preceptor must demonstrate thorough knowledge of the Northwest Community EMS System Policies, Procedures, and SOPs.

II. **POSITION DESCRIPTION**: A Preceptor shall

A. complete a preceptor orientation class given by the Resource Hospital prior to the first preceptor assignment and again once every two years if changes in practice or field internship processes have occurred.

B. be responsible and accountable for decisions made regarding patient care when working with their student.

C. orient, teach, and coach their assigned student during all supervised experience.

D. complete sequential, objective, and fair evaluations which quantify achievement of the objectives and measure performance against System standards. Their judgment will be consulted and heavily relied upon when considering a candidate for licensure/recognition; therefore, areas of strengths as well as continued learning opportunities must be specifically documented on the evaluations.

**Northwest Community EMS System** — **POLICY MANUAL**

| Policy Title: **PEER EDUCATORS I-IV / IDPH Lead instructors** | | | No. P - 7 |
|---|---|---|---|
| Board approval: 9-12-19 | Effective: 9-12-19 | Supersedes: 7-1-10 | Page: 1 of 6 |

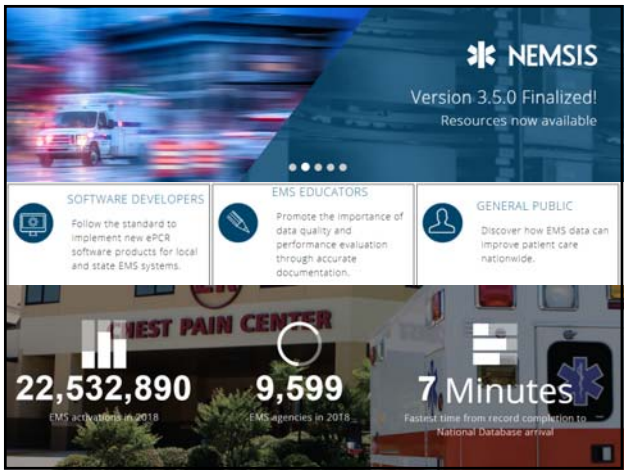
I. **Policy**

A. An EMS education program shall only be conducted by an EMS System or an academic institution under the direction of the EMS System. Oversight, quality assurance and outcome measurement for all EMS education programs shall be the responsibility of the EMS MD and the EMS System Coordinator, with cooperation of the educational institution/program and lead instructors (EMS Rules Section 515.500)

B. Source standards
1. National EMS Education Standards (current edition)
2. National EMS Scope of Practice Model skills (2019)
3. Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP)
4. Additional course curricula required by IDPH and/or the Resource Hospital

C. All NWC EMSS personnel shall be taught, tested, and/or have competency measured by qualified and competent educators using evidence-based content and methods of instruction that foster mutual respect and an active learning environment. Definitions of competency:
1. The measurable and observable knowledge, skills, ability and behaviors that a person demonstrates in order to perform responsibilities correctly and skillfully.
2. The application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the practice role.

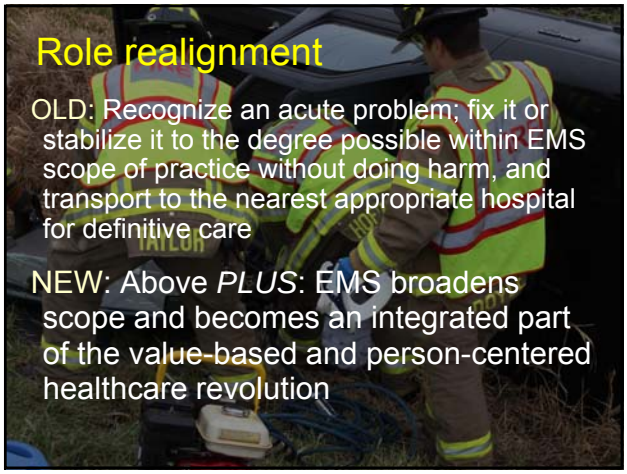
D. EMS-related education for EMS personnel of all levels shall be coordinated by at least one approved Illinois Lead Instructor. A program that includes education, training, or QI for

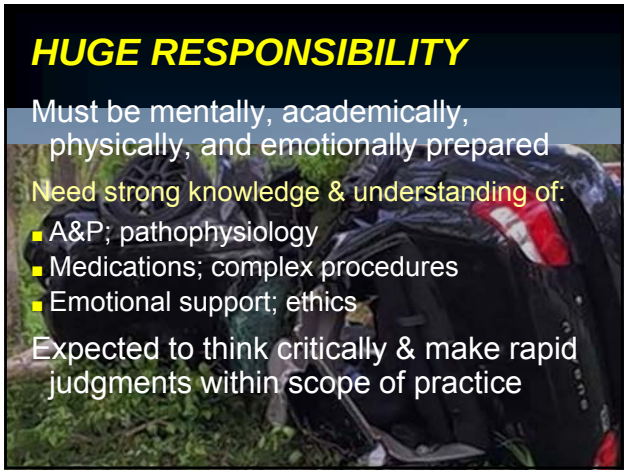

NEMSIS
Version 3.5.0 Finalized!
Resources now available
SOFTWARE DEVELOPERS
Follow the standard to implement new ePCR software products for local and state EMS systems.
EMS EDUCATORS
Promote the importance of data quality and performance evaluation through accurate documentation.
GENERAL PUBLIC
Discover how EMS data can improve patient care nationwide.
22,532,890
EMS activations in 2018
9,599
EMS agencies in 2018
7 Minutes
Fastest time from record completion to National Database arrival


ems.gov
Powered by NHTSA's Office of EMS
RECEIVE EMAIL UPDATES
HOME
PROJECTS
INITIATIVES
FICEMS
NEMSAC
NEWS & EVENTS
EMS and Healthcare Data Integration
The vision set forth in EMS Agenda 2050 calls for a people-centered approach to EMS that includes a more seamless, less siloed system. A key piece of that effort will be better integration of pre-hospital, hospital and other healthcare data. Integrating data systems and allowing more access to critical information can help pre-hospital, hospital and other clinicians provide safer, more effective and more efficient patient care.


Paramedic roles evolving
Advances in technology, costs, reimbursement, value-based care, need for integration, trends in patient populations (increasing # elderly) are rapidly driving change


So, EMS education must change with the times and emphasize the integration of EMS within the overall health care system


Role realignment
OLD: Recognize an acute problem; fix it or stabilize it to the degree possible within EMS scope of practice without doing harm, and transport to the nearest appropriate hospital for definitive care
NEW: Above *PLUS*: EMS broadens scope and becomes an integrated part of the value-based and person-centered healthcare revolution


HUGE RESPONSIBILITY
Must be mentally, academically, physically, and emotionally prepared
Need strong knowledge & understanding of:
A&P; pathophysiology
Medications; complex procedures
Emotional support; ethics
Expected to think critically & make rapid judgments within scope of practice

Our program of instruction;
accreditations,
outcome points of education
domains of learning;
critical thinker traits
General course objectives
Core values

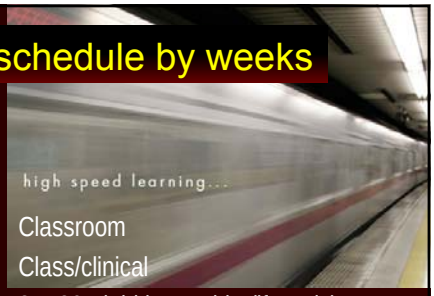

## Our relationship with Harper College

Dual enrollment; taught at NCH; Harper credits
Certificate courses (38 credits); AAS degree

## Instructional design

| | | Credit hours |
|---|---|---|
| EMS 110 | EMT Education | 9 |
| Paramedic CERTIFICATE Program | | |
| EMS 210 | Preparatory (fall) | 10 |
| EMS 211 | Med. Emerg I (fall) | 5 |
| EMS 212 | Med. Emerg II (spring) | 7 |
| EMS 213 | Trauma, special populations | 6 |
| EMS 217 & 218 | Hospital Internship | 3 |
| EMS 215 | Field Internship (spring) | 4 |
| EMS 216 | Seminar (summer) | 3 |
| Total PM Certificate hours | | 38 |

## Program schedule by weeks




| | |
|---|---|
| Weeks 1-6: | Classroom |
| Weeks 7-23: | Class/clinical |
| Weeks 24-35: | 3-1-20 Field internship (if ready) |
| Weeks 36-39: | Paramedic seminar |
| Graduation! | June 10, 2020 |
| NREMT Practical: | June 19, 2020 |

In addition to EMT and PM certificates:
Required courses for Assoc. in Applied Science (AAS):

| | |
|---|---|
| BIO 160 Human Anatomy | 4 |
| BIO 161 Human Physiology | 4 |
| Electives[1] | 4 |
| ENG 101 Composition | 3 |
| NUR 210 Physical Assessment | 2 |
| SOC 101[+] Introduction to Sociology | 3 |
| SPE 101 Fund. of Speech Communication | 3 |
| Total credit hours for AAS degree | 70 |

1Electives: BIO 130, CHM 100, HSC 104, or HSC 213
+ This course meets World Cultures and Diversity graduation requirement.

The Joint Commission

Higher Learning Commission North Central Association

CAAHEP Commission on Accreditation

Credible education is accredited

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

*Accreditation* evaluates programs relative to standards and guidelines developed by national communities of interest

Entry level competence assured by curricula standards, *national* accreditation, testing


CoAEMSP Interpretations of the CAAHEP Standards and Guidelines

For the Accreditation of Educational Programs in the EMS Profession

Evaluation of the clinical and field internship sites should be done by the program. They should ensure, through tracking (Standard III.C.2) that the clinical and field internship sites provide the minimum requirements for competency (See II.C and IV.A.1).

| CoA-Standards | Interpretations |
|---|---|
| Standard III.A.2. Hospital/Clinical Affiliations and Field/Internship Affiliations<br>For all affiliations, students must have access to adequate numbers of patients, proportionally distributed by age range, chief complaint and interventions in the delivery of emergency care appropriate to the level of the Emergency Medical Services Profession(s) for which training is being offered.<br>The clinical/field experience/internship resources must ensure exposure to, and assessment and management of the following patients and conditions: adult trauma and medical emergencies; airway management to include endotracheal intubation; obstetrics to include obstetric patients with delivery and neonatal assessment and care; pediatric trauma and medical emergencies including assessment and management, and geriatric trauma and medical emergencies. | The program must set and require minimum competency numbers of patient contacts for each listed category. Those minimum numbers must be approved by the Medical Director and endorsed by the Advisory Committee with documentation of those actions. The tracking documentation must then show those minimums and that each student has met them. There must be periodic evaluation that the established minimums are adequate to achieve competency. No minimum number can be fewer than two (2), including each pediatric age subgroup. Two patient encounters in each pediatric subgroup must be live and cannot be achieved through simulation.<br>The objectives must clearly state the intent of the rotation and outcomes required. While the specific units/rooms may provide the types of patients to meet the objectives, there are likely other locations and creative activities that can provide the necessary type of patient encounters.<br>In order for an interfacility transfer to be documented as a patient contact in the field experience or the capstone field internship, the patient must be transferred to a higher level of care requiring assessment and may require emergency care. |
| Standard III.A.1. Program Resources<br>Program resources must be sufficient to ensure the achievement of the program's goals and outcomes. Resources must include, but are not limited to: faculty; clerical and support staff; curriculum; finances; offices; classroom, laboratory, and | 1) As part of the administration, organization, and supervision of the program, the Program Director must ensure that there is preceptor orientation/training.<br>The training/orientation must include the following topics:<br>• Purposes of the student rotation (minimum competencies, skills, and behaviors)<br>• Evaluation tools used by the program |

## Outcome points for EMS Education:

Graduates have achieved the competency in all three domains of learning required for practice that ensures the delivery of safe, timely, efficient, effective, equitable, compassionate and person-centered care to serve the health care needs of the population.

## Outcome-based education Bridge to developing:

- Lifelong learners
- Knowledgeable persons with deep understanding
- Complex thinkers
- Creative persons
- Active investigators
- Effective communicators
- Reflective and self-directed learners

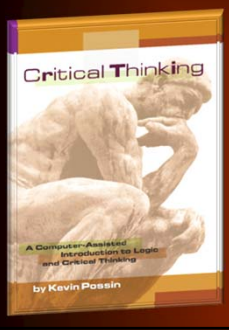
## Bloom's Taxonomy

Objectives guide teaching & map to measurement

| Cognitive | Psychomotor | Affective |
|---|---|---|
| Creating | (What they can do) | (Values & attitudes) |
| Evaluating | Naturalization | Characterization |
| Analyzing | Articulation | Organization |
| Applying | Precision | Valuing |
| Understanding | Manipulation | Responding |
| Remembering | Imitation | Receiving |

## Critical thinker traits

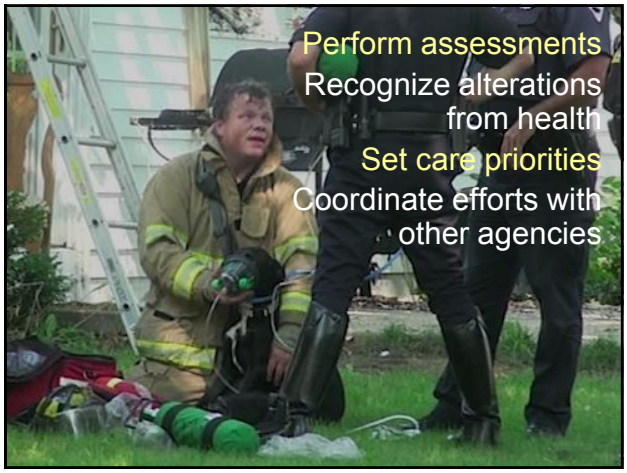
Strive for intellectual ends such as **clarity, precision, accuracy, relevance, depth, breadth, and logicalness**



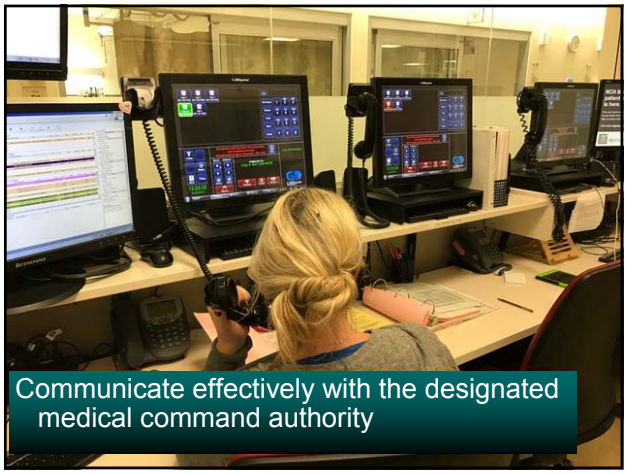

## General course objectives


**Upon completion, graduates will demonstrate safe entry level competency in the following:**
Assess scene safety and demonstrate effective situational awareness.

## Patient access

Perform assessments
Recognize alterations from health
Set care priorities
Coordinate efforts with other agencies



Communicate effectively with the designated medical command authority

Give interim and handover reports
Document ***any*** changes or delays
Effectively communicate with ***all*** involved

Establish rapport to decrease anxiety and meet emotional and physical needs

## General course objectives cont.

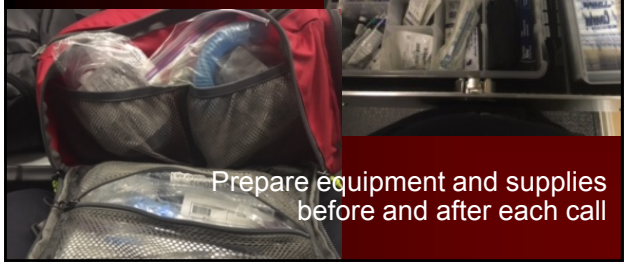

Provide BLS to ALS care as prescribed by EMS MD

Exercise critical judgment where OLMC has been delayed, interrupted or aborted

Thoroughly and accurately document an ePCR using Image Trend software

## General course objectives cont.

Maintain inventories per Drug & Supply List



Prepare equipment and supplies before and after each call

## Core values set our compass

Integrity
Compassion; Commitment; Citizenship
Accountability; Advancing knowledge
Respect and Collaboration
Excellence
Justice

## Accepts responsibility

"We must reject the idea that every time a law's broken, society is guilty rather than the lawbreaker. It is time to restore the American precept that each individual is accountable for his actions." ~ Ronald Reagan

## Value of EI to students

Self-assessment

Ability to perceive/understand emotions & motives in others and self-regulate own emotions

Improvement in non-verbal communication and listening skills

Pts must feel safe, secure, respected

Show sensitivity to those who are vulnerable

Ability to show empathy, consideration and care

## Ethics in the internship

Must prominently wear student ID

Pt may refuse to allow a student to perform a procedure

Limit # of invasive ALS skill attempts made by students

## Patient advocacy

Defend patient's rights

Place patient's needs first unless safety threat

Disagree without being disagreeable

Protect confidentiality

## Field internship Requirements Core competencies

## EMS 215 – Field internship

Minimum 300 clock hours plus meetings

CoA prefers closer to 700 hours

**WILLIAM RAINEY HARPER COLLEGE**
**HEALTH CAREERS DIVISION**
**NORTHWEST COMMUNITY HEALTHCARE PARAMEDIC PROGRAM**
**COURSE SYLLABUS**

| EMS | 215 | PARAMEDIC: FIELD INTERNSHIP | (0 / 20) | 4 |
|---|---|---|---|---|
| Course Prefix | Course Number | Course Title | (Lec-Lab) | Credit Hours |

Connie J. Mattera, M.S., R.N., PM
Program Director
Michael Gentile, BA, PM, Lead Instructor
Northwest Community Hospital (NCH)
800 W. Central Rd. EMS Offices in Behavioral Health/901 Kirchoff Center
Arlington Heights, IL 60005
Office hours: M-F 0800-1700
Phone: 847.618.4402 (Secretary) #4490 (Mr. Gentile)
cmattera@nch.org or mgentile@nch.org

**Dates: February 28- May 15, 2020** and/or until all objectives and patient care contacts are achieved, no later than June 10, 2020 unless an extension is granted
Time & location of classes: EMS agencies within the Northwest Community EMS System
Class days: Dates and times variable depending on preceptor schedules and agency policies

**COURSE DESCRIPTION**

This course integrates the theoretical concepts and practical skills acquired during EMS 210, 211, 212, 213, 217, and 218 and requires students to use higher order thinking and critical reasoning to safely care for patients in the out of hospital environment under the direct supervision of an approved paramedic preceptor. The internship is divided into two phases of ascending mastery and accountability with each having a minimum number of patient care contacts and competencies. A full description of the objectives and expectations is contained in the NCH Paramedic Program Student Handbook and on the internship forms. (NOTE: This course has an additional fee of $1500 to cover the cost of preceptor supervision.)

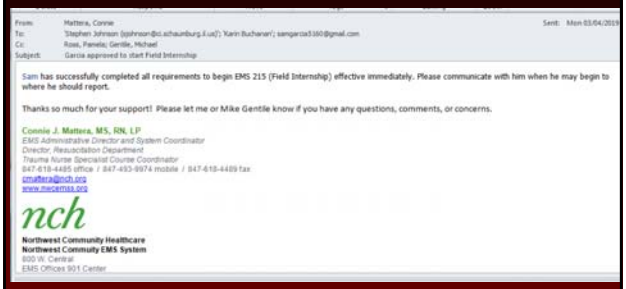
**Prerequisites for release to Field Internship:**

- Successful completion of EMS 213
- All initial Hospital clinical rotations (EMS 217 & 218) done except for the elective; paperwork approved by J. Dyer

## Prerequisites for Release to Field Internship

- Successful completion of EMS 213
- EMS 217 & 218 done (except elective); all paperwork submitted to & approved by J. Dyer
- Fisdap entries for labs and EMS 217 & 218 entered by student and approved by J. Dyer
- All simulated runs completed by student, submitted to and approved by J. Albert
- Eligible preceptor(s) identified & approved & paperwork submitted to M. Gentile
- Agency hosting agreements signed by authorized administrator and submitted to C. Mattera

## How will you know they are released to start?

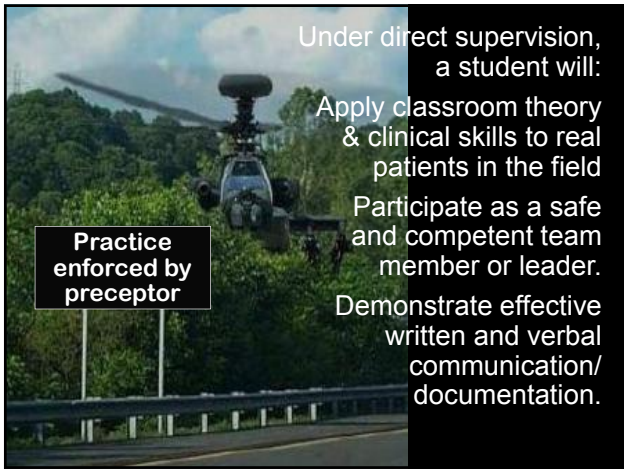


From: Mattera, Connie
To: 'Stephen Johnson (sjohnson@ci.schaumburg.il.us)'; 'Karin Buchanan'; sangarcia5360@gmail.com
Cc: Rose, Pamela; Gentile, Michael
Subject: Garcia approved to start Field Internship
Sent: Mon 03/04/2019

Sam has successfully completed all requirements to begin EMS 215 (Field Internship) effective immediately. Please communicate with him when he may begin to where he should report.

Thanks so much for your support! Please let me or Mike Gentile know if you have any questions, comments, or concerns.

Connie J. Mattera, MS, RN, LP
EMS Administrative Director and System Coordinator
Director, Resuscitation Department
Trauma Nurse Specialist Course Coordinator
847-618-4485 office / 847-493-8974 mobile / 847-618-4489 fax
cmattera@nch.org
www.necemss.org
nch
Northwest Community Healthcare
Northwest Community EMS System
800 W. Central
EMS Offices 901 Center



Practice enforced by preceptor

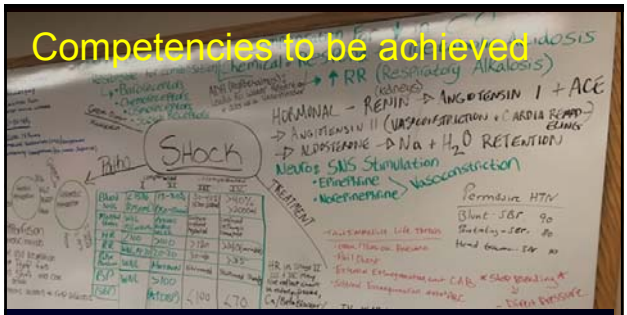
Under direct supervision, a student will:

Apply classroom theory & clinical skills to real patients in the field

Participate as a safe and competent team member or leader.

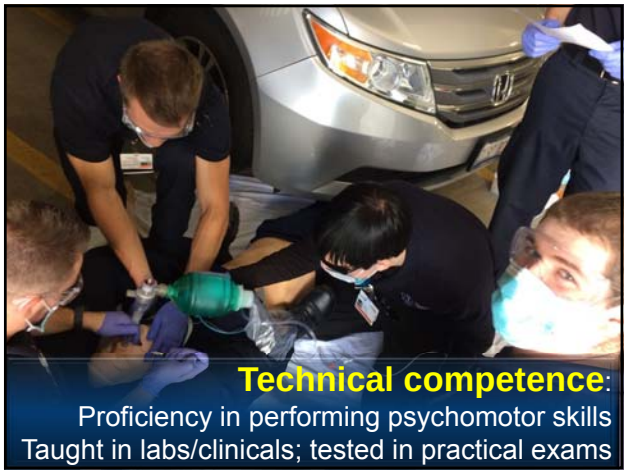
Demonstrate effective written and verbal communication/ documentation.

## Competencies to be achieved



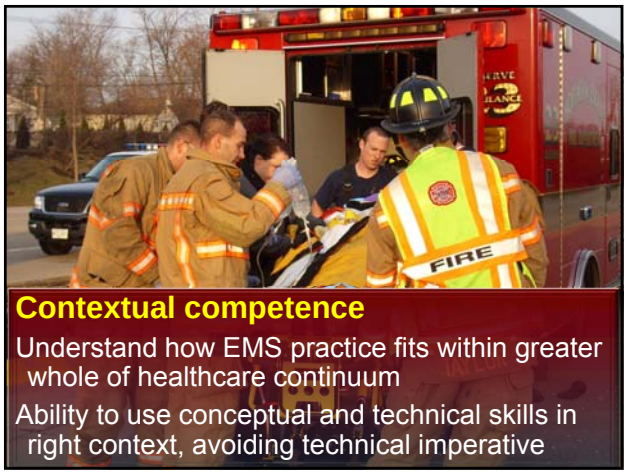

**Conceptual competence**:
Ability to understand theoretical foundations of the profession

Measured through quizzes, exams, mind maps



**Technical competence**:
Proficiency in performing psychomotor skills
Taught in labs/clinicals; tested in practical exams

Paramedics must be fully competent in all procedures




**Contextual competence**

Understand how EMS practice fits within greater whole of healthcare continuum

Ability to use conceptual and technical skills in right context, avoiding technical imperative

## Integrative competence

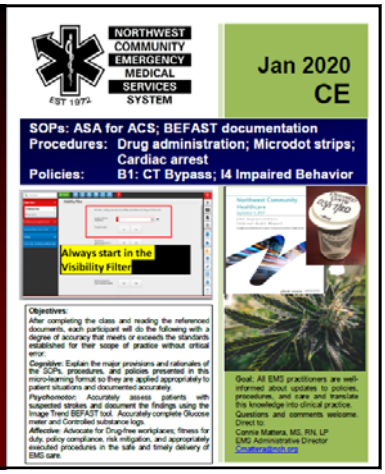
Ability to take all other competencies and put them together to meld theory and practice


**Adaptive competence**: Ability to change with evolutions in EMS or changing clinical presentations in one pt (move from 1 page of SOP to another)

*Challenge for us all due to constant pace of change~*


How well have we adapted to delay advanced airways, troubleshoot low $ETCO_2$ values obtained with apneic oxygenation, document initiation of manual CPR, use delayed defibrillation, document interventions in real-time, and determine arrests that need immediate transport?

How well are we adapting to these?




| Situation Provider Primary Impression (eSituation.11) | 2019 Number of Runs | 2019 Percent of Total Runs | 2018 Number of Runs | 2018 Percent of Total Runs |
|---|---|---|---|---|
| No abnormal findings upon Exam (Z00) | 18,488 | 23.00% | 16,175 | 21.13% |
| Acute pain (G89.1) | 5,581 | 6.94% | 5,756 | 7.52% |
| Weakness (R53.1) | 5,364 | 6.67% | 4,649 | 6.07% |
| Altered mental status (R41.82) | 2,363 | 2.94% | 2,172 | 2.84% |
| Chest pain (precordial) (R07.2) | 1,848 | 2.30% | 1,733 | 2.26% |
| Injury of head (S09.90) | 1,820 | 2.26% | 1,709 | 2.23% |
| Dyspnea / Other Respiratory Unspecified (J98.9) | 1,798 | 2.24% | 1,618 | 2.11% |
| Alcohol use, with intoxication (F10.92) | 1,666 | 2.07% | 1,609 | 2.10% |
| Suicidal ideations (R45.851) | 1,660 | 2.06% | 1,619 | 2.11% |
| Dizziness (R42) | 1,518 | 1.89% | 1,529 | 2.00% |
| Syncope (R55) | 1,466 | 1.82% | 1,518 | 1.98% |
| "Undocumented Primary Impression" | 1,342 | 1.67% | 1,356 | 1.77% |
| Anxiety disorder (F41.9) | 1,240 | 1.54% | 1,294 | 1.69% |
| Feared Complaint Unfounded (Z71.1) | 1,210 | 1.54% | 1,298 | 1.70% |
| Acute abdomen (R10.0) | | | | |
| Stroke / Cerebral Infarction (I63.9) | | | | |
| Generalized abdominal pain (R10.84) | | | | |
| Unspecified Convulsions / Seizure (R56.9) | | | | |
| Nausea and vomiting (R11) | | | | |
| Back Pain, non-traumatic (M54.9) | 873 | 1.09% | 832 | 1.09% |

*To correct documentation?*

*Failure to adapt can have some serious consequences!*


Scheduling and Sequencing of Field Internship
Expectations
Forms and documents
Phase meetings

Sailing ships into the future

EMS 215 Field Internship

Membership - Leadership

Teamwork and diplomacy

*EMS is a team sport!*
Must work well with others to achieve common goals
Team leader role crucial part of internship
Puts team success above own interest
Respect for all team members

See back of handout

**2018-2019 CoA Appendix G and Program Patient Contact and Skills with Stats**
**2019-2020 Patient Contact and Skills Recommendations**

TABLE 1

| Required Competencies, Skills, Ages, Differential Diagnoses, and Complaints on Patients in Clinical, Field Experience, or Capstone | CoA Rec Minimum | 2018-19 Program Required Minimum | 2018-2019 Avg / Mean | 2018-2019 Median | 2018-2019 Mode | Range | 2019-2020 Suggested Minimum | Notes |
|---|---|---|---|---|---|---|---|---|
| Trauma | 30 Total | 30 Total | 28.6 | 29 | Mult | 18-43 | 30 | |
| Trauma – Pediatric | 6 | | | | | | 6 | Not reported 2018-19; begin Fall 2019 |
| Trauma - Geriatric | 6 | | | | | | 6 | Not reported 2018-19; begin Fall 2019 |
| Pediatrics | 18 Total | 25 | 30.6 | 29 | 27 | 20-55 | 25 | |
| Newborn | 2 | 2 | 4.5 | 4.5 | Mult | 1-8 | 2 | Likely observed assessment only |
| Infant | 2 | 3 | 2.9 | 3 | 2 | 0-7 | 2 | |
| Toddler | 2 | 2 | 5.4 | 5 | 4 | 1-11 | 3 | |
| Preschool | 2 | 2 | 2.4 | 2 | 2 | 1-5 | 2 | |
| School-age | 2 | 3 | 5.7 | 5 | 5 | 2-11 | 3 | |
| Adolescent | 2 | 5 | 9.8 | 9 | 9 | 4-24 | 5 | |
| Medical | 60 Total | 60 | 61.5 | 60 | Mult | 44-80 | 60 | |
| Medical – Pediatric | 12 | | | | | | 12 | Not reported 2018-19; begin Fall 2019 |
| Medical – Geriatric | 12 | | | | | | 12 | Not reported 2018-19; begin Fall 2019 |
| Stroke / TIA | 2 | 2 | 3.9 | 4 | 4 | 0-9 | 2 | |
| Acute Coronary Syndrome | 2 | | | | | | 2 | Not reported 2018-19; begin Fall 2019 |
| Cardiac Dysrhythmia | 2 | | | | | | 2 | Not reported 2018-19; begin Fall 2019 |
| Resp Distress/Failure | 2 | 20 | 17.3 | 18 | Mult | 8-26 | 15 | |
| Hypoglycemia/DKA/HHNS | 2 | | | | | | 2 | Not reported 2018-19; begin Fall 2019 |
| Sepsis | 2 | | | | | | 2 | Not reported 2018-19; begin Fall 2019 |
| Shock | 2 | | | | | | 2 | Not reported 2018-19; begin Fall 2019 |
| Toxicological Event/OD | 2 | | | | | | 2 | Not reported 2018-19; begin Fall 2019 |
| Psychiatric | 6 | 6 | 14.1 | 14 | Mult | 7-21 | 6 | |
| Altered Mental Status | 2 | 8 | 19.7 | 19 | 18 | 7-31 | 8 | |
| Abdominal Pain (CC or Impr) | 2 | 4 | 11.3 | 10 | Mult | 4-24 | 4 | Chief Complaint or Impr |
| Chest Pain | 2 | 8 | 13.5 | 12.5 | 8 | 6-29 | 8 | This CC may also satisfy Impr of ACS |

PM student portfolios required; let's look at EMS 215 forms and paperwork

## Sequence

***How long will it take?***


## Phase meetings

*Who?* Student, preceptor(s), Hospital EMSC/educator; PEMSC welcome

*What is discussed? PCRs (assessment/ care/doc/disposition), drug cards, ECGs*

*Time estimation:*
Phase 1: 2-3 hrs
Phase 2: 3-4 hrs

## Prepare in advance for phase meetings

Evaluate as you go!

Complete Critique form after each run; schedule meetings well *in advance*

Ensure forms and paperwork (on cover sheet) are submitted at least 1 wk prior to meeting

Quiz student on pathophys., drug profiles and EMS care

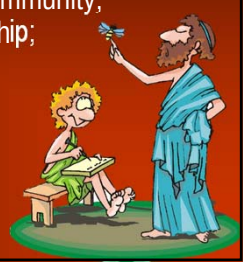
Review calls so you all can explain deviations from SOPs, receiving hospitals, scene times, and ensure PCR is thoroughly documented

## Roles and responsibilities of a preceptor

## *So, where do you come in?*

"After 25 years of research and $60 million later, what really moves diverse learners forward is a masterful teacher who commits the necessary energy to: create a learning community; provide a learning apprenticeship; and makes plans or content explicit enough so that all (learners) are on the journey!"

*Dr. Donald Deshler, Dir. Center for Research on Learning, U of Kansas*





## Characteristics of an effective preceptor

- Desire to be a supporter/ teacher
- Competency in specialty; models desired behaviors
- Effective interpersonal and communication skills
- Teaching skills; motivated to teach
- Sensitive to learning needs of students
- Leadership skills
- Effective decision making and problem-solving skills; can articulate reasons for actions while performing them
- Positive attitude; shows genuine interest in others
- Interest in professional growth (self & others)
- Ability to provide effective feedback (students & faculty)
- Is accessible to student for completion of projects/obj



## What are your strengths?

**PRECEPTOR SELF ASSESSMENT FORM**

**Instructions:**

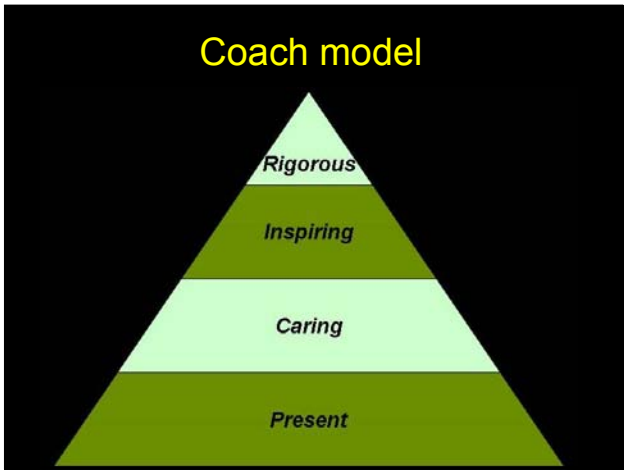
Use the following table to rate yourself in a manner that best represents your own attributes. Do not project an image of who you want to be. Give each attribute a ranking, from 1 to 5, based on the following rating scale:

**Rating scale:**

1= Never. Definitely not me
2= Rarely
3= Sometimes
4= Often
5= Always. This is who I am.

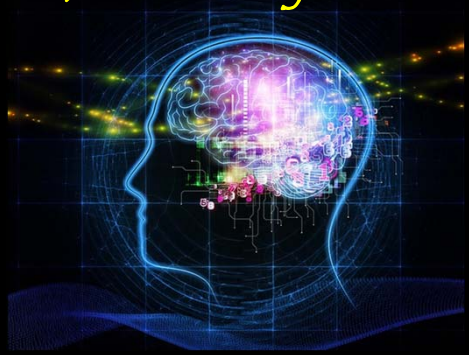
| Personal attributes | | Attitude attributes | |
|---|---|---|---|
| 1. Warm | | 1. Enthusiastic | |
| 2. Humorous | | 2. Respectful | |
| 3. Mature | | 3. Supportive | |
| 4. Self-confident | | 4. Concerned | |
| 5. Charismatic | | 5. Patient | |
| 6. Empathetic | | 6. Accepting | |
| 7. Trustworthy | | 7. Nurturing | |
| 8. Flexible | | 8. Effective in coping | |
| 9. Accountable | | 9. Professional | |
| 10. Experienced | | 10. Delegator | |

## Coach model



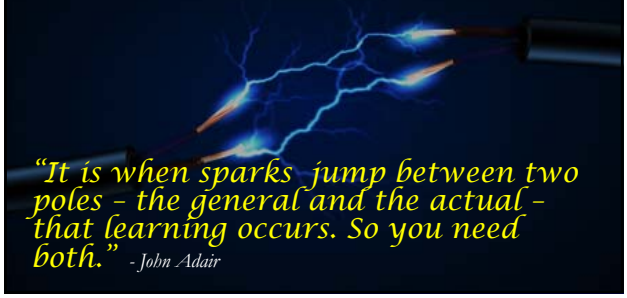

## Adult learners and adult learning theory

## We know what we are interested in knowing



## Unleashing the learning potential

**Learning** = Interaction of principles/theory
+
Experience/practice



*"It is when sparks jump between two poles – the general and the actual – that learning occurs. So you need both."* - John Adair

## Application to adult learning theory

Motivated to learn based on need

Involve in discovering value and relevance

Identify gaps in knowledge and skills


## Laws of learning

**Primacy**: First impressions are lasting

**Exercise**: Neural pathways strengthened by repetition

**Disuse**: Use it or lose it!

**Intensity**: Dramatic experiences using all domains of learning and higher level thinking with triggered emotions are more likely remembered


## Methods for planning a learning experience

## Adult learner characteristics

Participative; collaborative

Help plan their own learning experience/evaluation

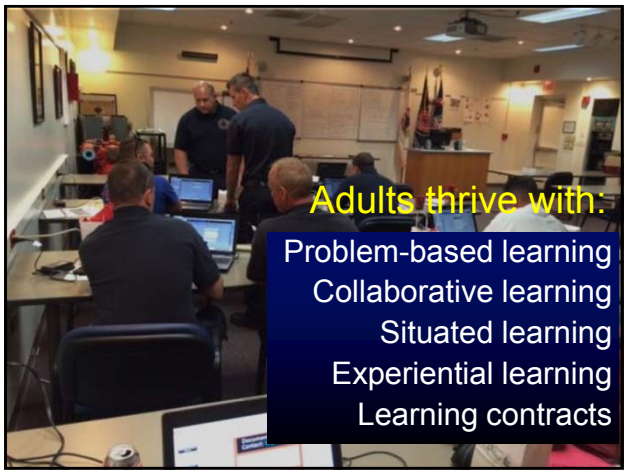
Impatient with time wasters

Prefer to be treated as peers

## Need to know ***why*** they are being asked to learn something

Have them state consequences of not knowing

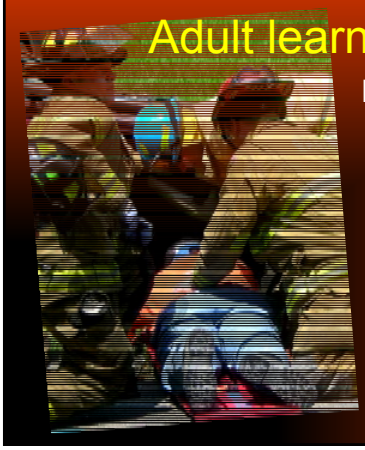
Clarify what they will be able to do better w/ knowing

## Adults thrive with:

Problem-based learning
Collaborative learning
Situated learning
Experiential learning
Learning contracts

## Adult learners



Learning must be embedded in authenticity

Make it real!

## Use experiential learning techniques

Build on previous learning while adding new experiences and knowledge

Try out new behaviors & acquire confidence and competence to do the job


## Staging of skill acquisition


You understand it only if you can teach it, use it, prove it, explain it, defend it, or read between the lines.

Wiggens & McTighe, 1998

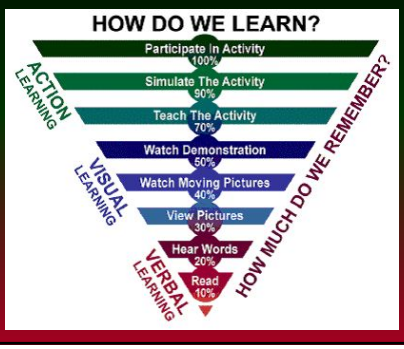
## 6 facets of understanding

When we truly understand, we…

- Can explain (generalize, connect, provide examples)
- Can interpret (tell accessible stories, provide dimension)
- Can apply (use what we know in real contexts)
- Have perspective (see points of view through critical eyes)
- Can empathize (walk in another's shoes, value what they do)
- Have self-knowledge (metacognitive awareness, know what we don't know, reflect on meaning of learning and experience)

Fijor, M. (2010) Understanding by design and technology. Arlington Hts School District 25, ICE 2010. Accessed on line: http://www.slideshare.net/mfijor/understanding-by-design-and-tech-integration

## Use evidence-based, best practice models of effective education methods to achieve enduring learning




## Non-cognitive factors in education

Students must reframe failure as a learning experience rather than a label; learn from their failures to change their study strategy

They must learn metacognition – learn how to learn - and develop self-awareness; discover how they best take in, process, retain, retrieve and use information on the road to proficiency

## Because of your presence…

Students understand System expectations

Patients are safeguarded

You can *NEVER* condone sub-standard performance

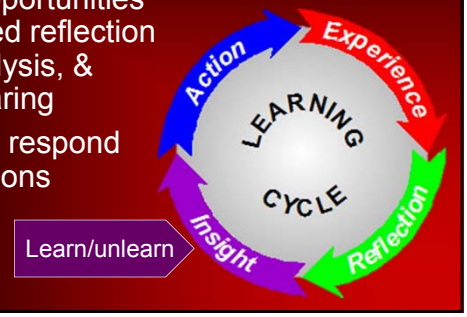
What's wrong here?

## *How do they get there?*


## Keys to success

Individualize instruction
Discuss goals for each shift
**Teach, don't preach**
Guide students to find solutions; don't lecture to submission!
Consult *reliable* sources
Ask probing questions; encourage problem solving
Use affirmation when possible
Provide timely feedback

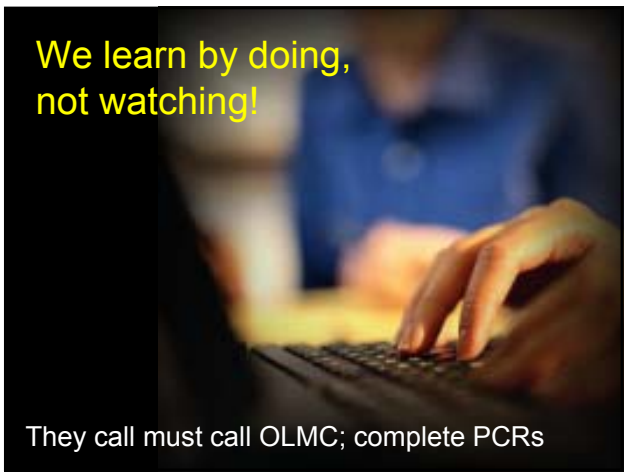
- Discuss patient calls, case studies, or simulations that require problem-solving activities
- Create opportunities for guided reflection and analysis, & idea-sharing
- Invite and respond to questions




Learn/unlearn

## Individualize instruction

- Clarify objectives of each phase **before** it starts
- Go over paperwork together
- Discuss goals at the beginning of each shift
- Apply theory to practice by having them perform assessments, interpret data, determine priorities; perform skills *with your supervision* unless pt's condition requires immediate interventions




They call must call OLMC; complete PCRs

*"A 60 year old patient c/o of severe abdominal pain. The pain was located in the center of the patient's abdomen causing him extreme discomfort."*

*"A 60 y/o pt c/o severe midline abdominal pain proximal to the navel radiating to the back rated 9 on a 0-10 scale. The pt described pain as sharp & stabbing starting abruptly 15 min ago while resting. Abdomen has generalized guarding but no rigidity to light palpation in both upper quadrants."*

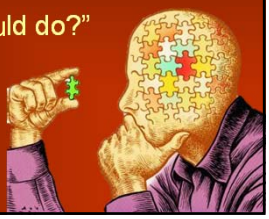

Strategies for evaluating performance and giving feedback; criteria for evaluation; conflict resolution


## Preceptor framework

**Step 1: Get a commitment**

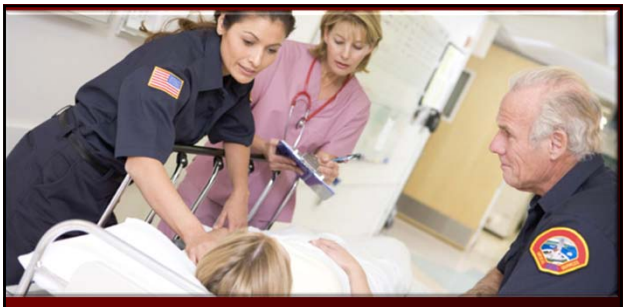
"What do you think is going on with this patient?"
"What other problems should you consider?"
"What assessments are needed?"
"What do you think we should do?"

*Gain insight into student's reasoning*



## Step 2 Probe for supporting evidence

"What factors support your conclusions? Which do not?"
"Why choose that particular drug?"
"Why is it important to do that assessment in this situation?"
Observe critical reasoning and help student to improve

Actively listen; reflect, paraphrase
Avoid temptation to say, "Here is how I do it."

## Step 3: Reinforce what was done well

Student may be unaware if they've done something well

Acknowledge their accomplishments

Be specific

Enhances self-esteem and reinforces behaviors you would like repeated


## Provide praise

Don't assume excellence is expected so praise is unnecessary

Changing and maintaining new behavior requires praise

Praise, like criticism, should be well timed, well targeted and well said

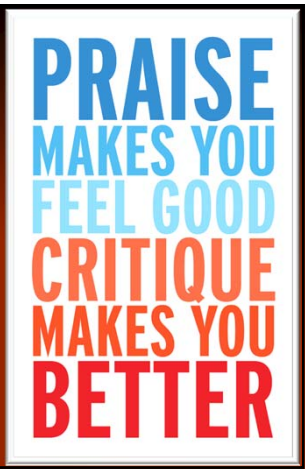

## Reinforce what was done well

"Your diagnosis of probable pneumonia was well supported by your history and physical exam. You integrated them well in reaching the correct field impression."

"Your radio call-in was well organized. You clearly stated the chief complaint, Hx and PE findings as well as our interventions and ETA. Good job!"

## Evaluation and feedback

Well timed, targeted and said corrective feedback can direct growth, motivate student and offer relief from confusion




## 4. Give corrective feedback

Share thoughts and feelings appropriately, *address behavior* rather than the student

*Judge the person, and you risk the relationship*

*Judge the behavior, and you take the bite out of criticism*


What worked well?
What could be changed to be better?

"What would be a better approach next time?"

"What change in technique might be more successful?"

"What could we do better as a team next time?"

## Feedback re: errors & omissions

"This patient may not have chest pain, but they are a long standing diabetic and are complaining of severe weakness and shortness of breath. Why is a 12-lead ECG necessary for this person?"

## Feedback re: errors & omissions

"People in pulmonary edema usually need CPAP, but the BP just dropped to 84/56 after the first NTG. What could C-PAP do to this patient?"

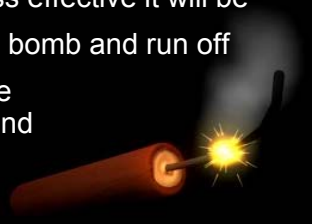
## Must be timely

Well-timed criticism should be delivered shortly after error

Longer you wait, less effective it will be

Be fair; don't drop a bomb and run off

Give student chance to process & respond

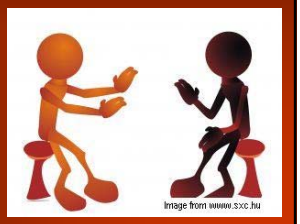


## Your preparation

Think through what you will say in advance

Don't talk when angry, tired, hungry or pressed for time

Right time,
place,
facts,
focus,
words



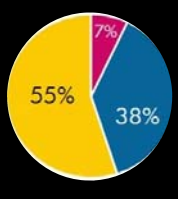

## Student's preparation

Assess readiness to receive information
"Is now a good time to talk?"


## Elements of personal communication

55% body language
38% tone of voice
7% spoken words

Why e-mail messages are often misinterpreted…




## Pace learning

Too much at once not helpful

"What's the most important teaching point right now?"

Giving too much feedback at once, is like taking a drink from a fire hydrant

If badly timed, student will be too over-whelmed to hear the message even if criticism is valid

Student will keep a safe distance and all future praise will be received with suspicion

## Intervene early

If student fails to meet objectives, don't allow them to fall hopelessly behind

Contact PEMSC & hospital EMSC/ educator; design individualized education program to overcome gaps


Northwest Community Healthcare Paramedic Program
Individualized Education Plan (IEP) - 2020

Please TYPE or PRINT

Student name: _____ EMS Agency: _____

Preceptor(s): _____

Standards of Performance Reviewed

| | | |
|---|---|---|
| ☐ Accountability | ☐ Follow up/follow through | ☐ Persistence |
| ☐ Appearance & personal hygiene | ☐ Integrity | ☐ Self-motivation |
| ☐ Assessment (patient, situational) | ☐ Knowledge | ☐ Self-confidence |
| ☐ Communication delivery of service | ☐ Patient advocacy | ☐ Team leadership |
| ☐ Communication (team/OLMC) | ☐ Planning | ☐ Technique/skill proficiency |
| ☐ Critical thinking | ☐ Prioritization & delegation | ☐ Time mgt, response, transitions, care |
| ☐ Empathy | ☐ Policy/protocol compliance | ☐ Teamwork & diplomacy |

(Other: Please explain) e.g., acting outside of scope of practice

Issue findings and Action plan

There are areas of your practice/performance in which improvement/change is required to fully meet program objectives. It is our intent to make you aware of the situation, provide specific feedback, and work with you to create an action plan designed to align your practice with program expectations. Please see the specific cause(s) for concern and action strategies below. We will re-evaluate as specified to assess your progress and determine further actions.

| Performance inconsistent with standards | Performance expectations/ Dose Benchmarks / Strategies for Improvement/Goals |
|---|---|

Managing student behaviors that compromise learning

## How should you deal with outliers?

## Student 1

26 y/o f is riding with your agency

She tries to fit in but is sometimes better able to dish it out than take it.

Her skills are marginal but safe , but she dissolves into tears when she is teased and the crew members are not happy with her being there.

Action needed?

## Student 2

27 y/o employee is preparing for medical school. He is very intelligent and challenges everything he believes is incorrect or inconsistent with what he read or was taught in class.

He sometimes teeters on crossing the line between disrespect and asking a heart question.

What's the best approach to this student?

## Student 3

24 y/o employee has been an EMT-B with a private agency for 4 years

He is very quiet and usually stands in the background at every call. He must be told to do any ALS assessments or interventions, but performs competently when instructed.

How should you coach this student?

## Student 4

32 y/o employee who's ticket finally came up and he had to come to PM class. Not happy about being here. He demonstrates a great deal of confidence and a take charge attitude, but instincts are not always correct and some skill techniques are marginal.

He becomes very defensive when you attempt to correct his errors

How should you coach this student?

## Student 5

25 y/o male is riding with your agency

He has been late 3 times and has called off twice. Talks a good game, but seems to have significant knowledge gaps. Has a part time job at an area hospital. Does not follow through on paperwork as directed. When confronted about his behavior he claims frequent illness.

It's 4 weeks into the internship and he is not progressing in the affective objectives.

What is the best approach with this student?

## Student 6

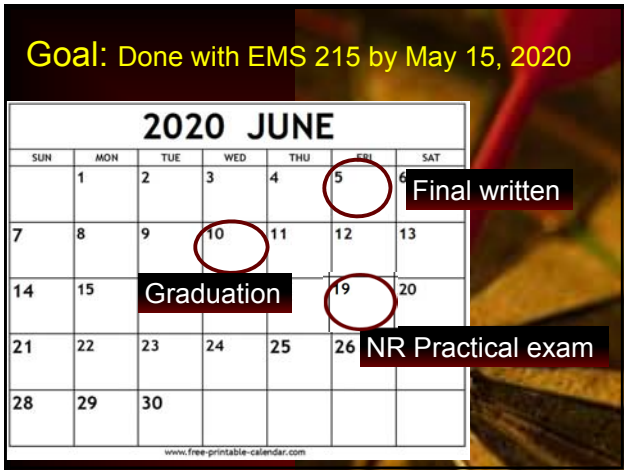
28 y/o rider is strongly motivated to become a PM

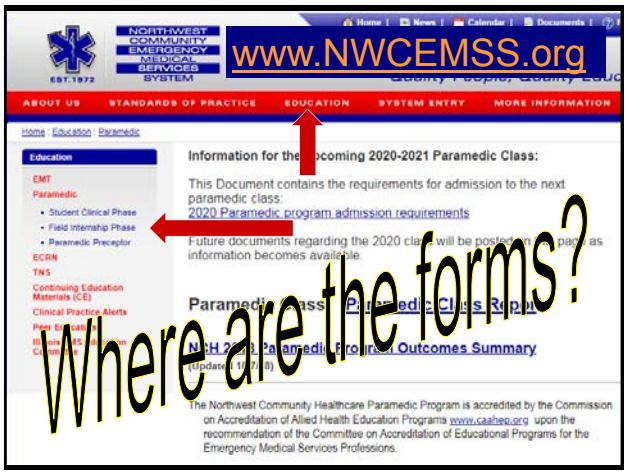
He is first out to the ambulance, volunteers to assist with cooking, housework, and is very respectful of agency members

He has minimal recall of class concepts and gets ECG rhythms totally confused. When asked what fentanyl is, he stares at you blankly.

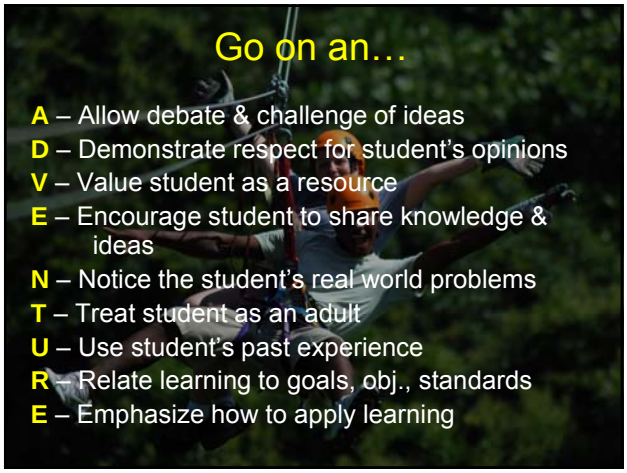
What is the best approach with this student?

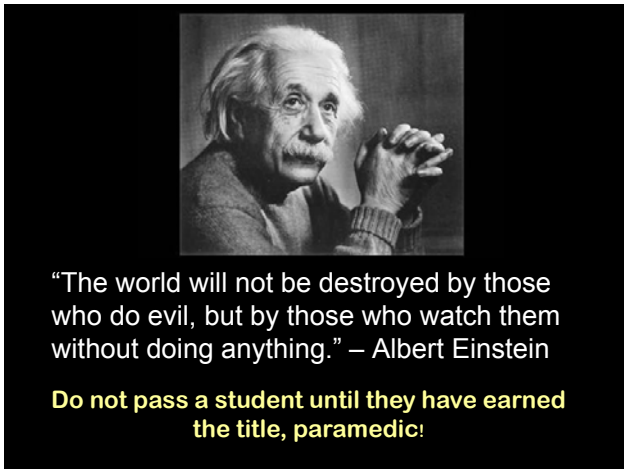
## Goal: Done with EMS 215 by May 15, 2020

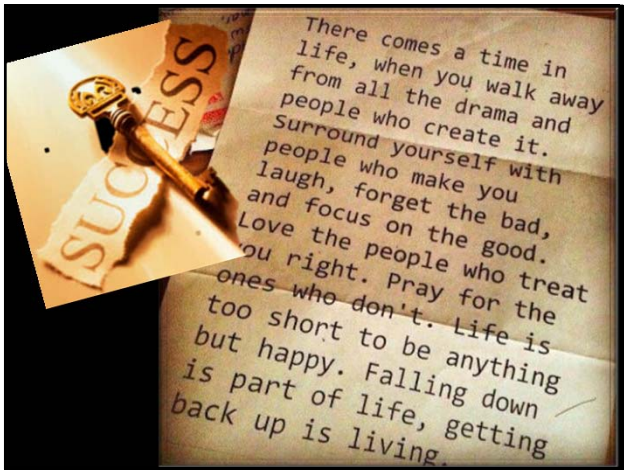



www.NWCEMSS.org
Where are the forms?
NORTH-WEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
ABOUT US
STANDARDS OF PRACTICE
EDUCATION
SYSTEM ENTRY
MORE INFORMATION
Education
EMT
Paramedic
Student Clinical Phase
Field Internship Phase
Paramedic Preceptor
ECRN
TNS
Continuing Education Materials (CE)
Clinical Practice Alerts
Information for the coming 2020-2021 Paramedic Class:
This Document contains the requirements for admission to the next paramedic class:
2020 Paramedic program admission requirements
Future documents regarding the 2020 class will be posted on this page as information becomes available.
Outcomes Summary
The Northwest Community Healthcare Paramedic Program is accredited by the Commission on Accreditation of Allied Health Education Programs www.caahep.org upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions.


Tricks are great but work best in the hands of a skilled magician!


Go on an…
A – Allow debate & challenge of ideas
D – Demonstrate respect for student's opinions
V – Value student as a resource
E – Encourage student to share knowledge & ideas
N – Notice the student's real world problems
T – Treat student as an adult
U – Use student's past experience
R – Relate learning to goals, obj., standards
E – Emphasize how to apply learning


"The world will not be destroyed by those who do evil, but by those who watch them without doing anything." – Albert Einstein
Do not pass a student until they have earned the title, paramedic!


There comes a time in life, when you walk away from all the drama and people who create it. Surround yourself with people who make you laugh, forget the bad, and focus on the good. Love the people who treat you right. Pray for the ones who don't. Life is too short to be anything but happy. Falling down is part of life, getting back up is living.


cmattera@nch.org
www.nwcemss.org
Questions?
Comments?
Concerns?
Suggestions?
Send me a note (e-mail)