NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
EST 1972

Northwest Community EMS System

Provider EMS Coordinator Guidelines - 2018

Provider EMS Coordinators (PEMSCs) collaborate with the Resource Hospital EMS staff to plan, organize, implement, and evaluate Northwest Community EMS System (NWC EMSS) activities. This document shall serve as a reference guide for all PEMCS in the NWC EMSS. It will be amended as necessary.

Table of Contents

Revised October 30, 2018

Foundational assumption:

To function as a unified System, we MUST BE CONSISTENT and fair in how all policies, procedures and guidelines are implemented and applied. We must never knowingly or intentionally show preference to, or adversely discriminate against, any student, System member, patient, or stakeholder.

Approved: 9/24/99; rev. 7/28/00; 3/03; 7/23/04; 6/30/06; 8/22/08; 2/25/11; 9/1/11; 10/6/11; 7/5/12; 8/1/12; 3/18; 6/18; 9/18; 10/30/18

I. ABOUT US

A. **Statutory authority and regulatory oversight:** Illinois Emergency Medical Services (EMS) Systems Act (210 ILCS 50) and TITLE 77: Public Health Chapter I: Department of Public Health Subchapter f: Emergency Services and Highway Safety Part 515 Emergency Medical Services, Trauma Center, Comprehensive Stroke Center, Primary Stroke Center and Acute Stroke Ready Hospital Code. Multiple additional laws, rules, and regulations impact EMS and are referenced within System documents. See http://dph.illinois.gov/topics-services/emergency-preparedness-response/ems

The IDPH EMS website contains all the forms and instructions a PEMSC needs for engaging with the state. DO NOT use old forms that have been saved in paper or electronic files. They are likely to be obsolete and will not be accepted by IDPH.

B. The **Northwest Community EMS System (NWC EMSS)** was **founded** by Dr. Stan Zydlo working in collaboration with Northwest Community Hospital (NCH) CEO Malcolm MacCoon, Jan Schwettman (an Inverness community activist), nine local EMS Services, and the newly created Illinois Department of Public Health Division of EMS and Highway Safety (IDPH). The System began operations on Dec. 1, 1972 with <100 paramedics and EMTs. We were proudly the first **Resource Hospital** for a Mobile Intensive Care Unit (MICU) System in Illinois and the first multi-community EMS System in the nation.

C. A Resource hospital is charged with the **total responsibility for the entire EMS program** including all clinical aspects, operations, and educational programs through its EMS Medical Director (EMS MD) (IDPH EMS Rules).

NWC EMSS EMS MDs

1. 1972-1996: Stanley M. Zydlo, MD, FACEP
2. 1996-2016: John M. Ortinau, MD, FACEP, FAEMS
3. 2017 to present: Matthew T. Jordan, MD, FACEP

D. Today, we are composed of 24 **EMS Agencies** (see tables 1 and 2) that employ over 1600 paramedics (PMs), Emergency Medical Technician (EMTs) Emergency Medical Responders (EMRs), Prehospital Registered Nurses (PHRNs), Emergency Communications Registered Nurses (ECRNs) and Emergency Medical Dispatchers (EMDs). NCH is ably assisted by five **Associate Hospitals** (see table 3).

E. Our **service area** covers approximately 400 square miles. We serve a population in excess of one million persons, 24/7, every day of the year.

F. Illinois is divided into 11 **EMS/Trauma Regions** with Region 12 encompassing programs that border Illinois but participate under Illinois EMS/Trauma Rules. We are located within IDPH **Region 9** that also includes five other EMS Systems. Our **System number is 0907**.

Table 1: NWC EMS System Municipal Agencies			
Arlington Heights FD	Des Plaines FD	Lake Zurich Fire/Rescue	Palatine Rural FPD
Barrington FD	Elk Grove Twshp FPD	Lincolnshire-RW FPD	Prospect Heights FPD
Barrington Countryside FPD	Elk Grove Village FD	Long Grove FD	Rolling Meadows FD
Bloomingdale FPD	Hoffman Estates FD	Mount Prospect FD	Schaumburg FD
Buffalo Grove FD	Itasca FD	Palatine FD	Wood Dale FPD

Table 2: NWC EMS System Private Ambulance Agencies		
Advantage Ambulance	Rescue Eight	Superior Ambulance Service
Federal: Fermilab BLS ambulance (Batavia)		

Table 3: NWC EMSS Associate Hospitals		
Alexian Brothers Medical Center	Resurrection Medical Center	Saint Alexius Medical Center
Glen Oaks Hospital	Good Shepherd Hospital	

G. **Patient demographics:** Patients range in age from the newly born to the elderly. Acuity ranges from non-emergent to life-threatening. In 2017, System personnel responded to over 72,000 calls for service.

H. **Scope of services:** EMS personnel demonstrate knowledge, skills and attitudes consistent with the expectations of the public and the profession. They are educated to assess and respond to a patient's physiological, psychological and emotional needs without discrimination and irrespective of medical diagnosis.

EMS goal: We exist to care for the right patient, in the right place, at the right time, based on patient need and choice and at the right cost through a fully integrated Care Coordination model that incorporates multiple care transitions and disciplines, EMS strives to provide comfort and prevent or reduce mortality and morbidity due to illness and injury and optimize a patient's health status as much as possible.

EMS scope of practice includes emergency medical dispatch, safe and timely response, patient access, assessments, interpretation of data, interventions, disposition decisions, transport, and monitoring within their scope of practice from the time of established duty until the transfer of responsibility to appropriate medical personnel or the patient is released. Basic and Advanced Life Support care is delivered as defined in the National EMS Scope of Practice Model, IDPH EMS Rules and Regulations, Region IX, and NWC EMSS protocols.

EMS personnel work collaboratively with other agencies, networks, and organizations. They are an essential component of the continuum of care and **serve as linkages among health resources**. As the scope of service expands, PMs will function as facilitators of access to care as well as treatment providers.

EMS personnel must be internally motivated, passionate about exemplary patient care, able to think critically, problem solve effectively, and relate well with people. Emerging roles and responsibilities include Mobile Integrated Healthcare, public education, health promotion, and participation in injury and illness prevention programs. All EMS personnel must demonstrate unquestionable ethical behavior driven by strong professional values. They shall take part in life-long learning, professional development, peer evaluation, and assume an active role in community outreach.

I. **Our Strategic planning process positions the System to anticipate, prepare for, and nimbly respond to environmental and industry changes**. System members collaborate annually to update the EMS Strategic Plan. They affirm or update the System **mission, vision and values statements** as needed. Person-centered care and customer satisfaction drive all processes. We place a high priority on teamwork and diplomacy; patient advocacy: protecting confidentiality; defending patient's rights, and placing patient's needs first. **See System EMS Strategic Plan on website.**

J. The System **embraces excellence** as a core value and we are **viewed as the gold standard of quality by customers and colleagues.** Our website gets hits internationally and we have been asked to send protocols, educational materials and other documents to individuals and programs throughout the US and countries all over the world.

K. **We believe that education is fundamental to professional growth and clinical excellence**. The entry level education programs achieve stellar outcomes and receive excellent feedback when reviewed by students, faculty, Advisory Committee members, employers, regulators and accrediting bodies. First attempt pass rates for EMT and paramedic graduates well exceed the National Registry of EMT (NREMT) testing averages. Our In-station CE program receives very positive feedback.

L. Successful health systems exhibit four **hallmarks of 'systemness'**

1. Clearly defined governance structures doing the right things at the right level
2. Hardwired roles and responsibilities for key stakeholders
3. Incentive structures that don't just support system goals but also don't encourage counterproductive behavior
4. Free flow of information—not just data, but knowledge and experience—that enables smarter, quicker action

M. **Shared governance model**

System initiatives are planned, organized, and implemented by multidisciplinary teams. Each group/committee has a charter that is updated annually (See System website).

EMS Advisory Board	Education Committee
EMS Chiefs/administrators	Provider Based Quality Improvement (PBPI) Committee
Provider EMS Coordinators (PEMSCs)	Research and Development (R&D) Committee
Hospital EMS MDs	Computer Aided Reporting System (CARS) Committee
Hospital EMSCs/educators	Cardiac arrest task force

II. **Advisory Board**

A. The NWC EMSS Advisory Board was established in 1979. It was the goal of the founders to create a board representing each of the System's constituent groups in order to reflect a diversity of opinion and viewpoints.

B. Charter Board members were appointed by the EMS MD in recognition for their leadership roles in the early System. Subsequent Board members have either been selected by their peers or appointed through a self-nomination/Board recommendation/EMS MD approval process. The **PEMSCs appoint a member and alternate each year.**

C. See Advisory Board charter and bylaws for Board charges and member selection/approval process. Current Board members and terms are posted on the System website. Calls for applications are generally are issued in November or December of each year and are due by early January. **Meetings**: 2nd Thursday, bi-monthly on odd numbered months at NCH.

III. **BUDGETING for EMS** – See annual handout and fee schedule document. Updated for FY 18-19.

IV. **COMPUTER AIDED REPORTING SYSTEM (CARS)**

A. The System is committed to complying with all Federal and state rules with respect to data collection, storage, retrieval, security and reporting.

B. The **CARS Committee** was chartered in 1995 to facilitate creation of electronic patient care report software for use by System members rather than the proposed state “bubble sheet”. It has evolved to oversee the System’s communication network that includes our electronic Medical Records as well as social media outreaches and the System website. The Committee is inclusive of each System agency and hospital (See EMS Strategic plan **Information Systems – Computer Aided Reporting System pages)** and meets on the 2nd Wed of each month at 9 am in the NCH Kirchoff Center.

C. **PEMSCs serve to facilitate CARS activities at their agency** in conjunction with their CARS Committee rep and/or Superusers. They shall ensure that all hardware, internet accessibility, and printing capabilities for the EMS electronic health reports are present and operational at all times and shall ensure that Information Technology (IT) support, HIPAA compliance, and failure recovery procedures are in place and known to EMS staff. See System **Policy D-4** Data Collection & Submission using ePCR software dated 12/1/16.

D. **Electronic Patient Care Reports** (ePCRs)/Health Records (eHRs): Per System vote, we are a member of the Region 8, 9, and 10 Image Trend consortium led by Patrick Sennett at Good Samaritan Hospital. This gives us a significant cost savings and access to software expertise as opposed to contracting with Image Trend individually. All NWC EMSS EMTs and PMs are required to complete ePCRs using the **Image Trend Elite platform** and **NWC EMSS templates** (created internally).

E. EMS Agencies are responsible for purchasing their own portable electronic devices on which data is entered and ensuring appropriate login access is available for their members and students. They are **billed annually** per run for Image Trend support in hosting the uploaded data and annually per each Elite license (See budgeting for EMS handout).

F. The System asks all hospitals to provide WiFi within the EMS chart room so agency computers can upload their runs directly to the cloud as well as wireless printing capability for devices that use Microsoft as well as Apple software.

G. If wireless printing is not available, hospitals are asked to have adequate printers and integrated connectivity capability available for rapid printing of reports across multiple hardware and software platforms. Hospitals are asked to work with the EMS agencies that transport to their location to ensure compatibility of print drivers. In the future, scanners or

software integration will be used to import EMS written documents into the hospital's electronic health records.

H. PEMSCs are given **Administrative Access** to the Image Trend database for their agency so they can activate new users, inactivate those no longer affiliated with their agency, unlock patient care reports and query data and/or provide QI notes on all patients that were cared for by their members. **Requests to link new members** already in the Region IX database at another EMS Agency shall be forwarded to Patrick Sennett at Patrick.Sennet@advocatehealth.com or psennett@gmail.com

I. PEMSCs shall attend appropriate training in advance of deployment of any new ePCR system. While CARS committee reps/Agency Superusers are accountable for conducting classes at their agencies, PEMSCs are expected to have an awareness level knowledge of the program and answer simple questions about connectivity and ensuring user expertise in completing the reports.

J. If a problem is encountered that cannot be corrected by the agency's CARS rep and/or IT department, notify the EMS Administrative Director, the CARS Committee chair Jim Klein (AHFD) jklein@VAH.com or Markus Rill (PHts) MRill@PHFire.com. If they are unable to assist you, we will contact the Region Image Trend Administrator (Patrick Sennett).

K. **System Website:** Address: www.nwcemss.org

1. Per System vote, the System contracted with American Eagle to create and maintain our website as a communication tool and repository of System documents. The website is also linked to the System Facebook page and Twitter feed.

2. Content specific to an individual agency or hospital may be posted but shall be submitted to the EMS Administrative Director in a publishable form (PDF) for review prior to posting.

3. Annual **Website support fee**: $40 per agency/hospital for website hosting and support paid to American Eagle. See budgeting for EMS document. NCH covers the cost to maintain our domain name and to support a webmaster that manages document posting to the site.

4. All System hospitals and agencies have full access to the website, including members-only pages as they are developed. Currently, the website has open access with no password protected pages.

V. **CONFIDENTIALITY** – Patients, EMS personnel, students and data

A. All PEMSCs have access to confidential information regarding patients, their EMS Agency, EMS personnel, students, and measurement instruments. Such information may only be read, taken, used, copied, and discussed in conjunction with the direct performance of one's duties and shared only with those who have a need to know. **See System Policies C-7: Confidentiality of Patient Records, E-5: Code of Ethics, and R-2: Review and Maintenance of EMS Personnel Files.** Please also reference your agency's internal policies re: Confidentiality of Records.

B. **Documents considered confidential**

1. **Student file information:** Students must sign a written academic release form before any aspects of their records are forwarded or confidential information is released to any other party (The Family Educational Rights and Privacy Act of 1974).The NCH paramedic program has these signed forms on all students.

2. All **EMS personnel file information** with respect to coaching notes and/or written warnings, RFCs, Individual Education Plan (IEPs), remediation plans, alleged misconduct investigations, QI reviews, suspensions, and/or disciplinary action; and/or post-exposure follow-up.

3. **Individually identifiable (protected) health information (PHI)** either in written, recorded, or electronic form. Access to patient records with protected or private health information (PHI) must comply with all Health Insurance Portability and

Accountability Act **(HIPAA)** guidelines**.** System agents (hospitals and EMS Agencies) may handle requests and release PCRs, but they must have written consent from patient/guardian to release a patient care report unless requested by subpoena or court order.

4. **Performance improvement data**: In the spirit of transparency, QI and/or statistical reports citing bundled or roll-up data by agency may be made public and may be posted to the website or published in CE documents. Drill down reports with confidential information by individual is only released to those with a need to know. ***See the Quality Management section of theses guidelines.***

5. Current and former **performance measurement tools** e.g., quizzes, exams, credit question keys, and competency measurement evaluation forms .

C. **Confidential documents must be stored and disposed of in a manner that protects the individual's privacy as much as is reasonably possible**

1. Draft copies of PCRs must be shredded or placed in containers that may not be accessed by any other personnel.
2. Copies of PCRs shall be stored or disposed of in a manner that protects them from scrutiny (in computer files that are inaccessible to other staff, shredded or placed in special recycling containers that disallow tampering or stored in locked cabinets).
3. PCRs, student records and EMS personnel files may be scanned for electronic storage. They must be saved for a minimum of seven years after generation. Files shall be stored in a manner that ensures record privacy and allows rapid but controlled access. Paper files must be stored in locked file cabinets or in cabinets located in space that is locked while unoccupied, and accessible only to EMS staff.
4. System financial information and CQI data may be disposed of as general waste per each agency's waste management plan.

VI. DIRECTORY (System) and Organizational Chart

A. The System maintains a directory of all hospitals and EMS agencies listing the names of key leaders and their contact information. This list is provided to IDPH, accreditors, and vendors for inclusion in special system pricing arrangements and is posted to the System website.

B. Provide notice to the EMS Administrative Director (e-mail) whenever there is a change in agency name, address, contact information, Chief/EMS CEO, or Provider EMS Coordinator.

C. It also publishes a System organizational chart noting key reporting relationships and agency assignments to System hospitals. See p. 19.

VII. EDUCATION PROGRAMS

Each agency is requested to send a representative to the System's **Education Committee** that meets every other month (odd numbered months) on the 1st Tuesday at 9 am. See System Strategic Plan section on Education Systems. **PEMSCs are responsible for the following**:

A. **Paramedic students**

1. System Chiefs/Administrators voted unanimously to support a standardized paramedic candidate/agency matching process to be implemented for the 2010-2011 academic year that continues to the present time. This approach has been highly successful in matching unaffiliated students with System EMS agencies and preceptors for the field internship. PEMSCs and chiefs are sent a Pooled Preceptor request form every spring to identify the number of unaffiliated students they are willing to host for the fall incoming class. The program proposes possible matches, but final acceptance is contingent on agency approval. See **Pooled Preceptor Program** for more details.
2. If aware that a possible **conflict of interest/relationship and/or bias to impartiality** may exist between an incoming student and an agency member, please notify the EMS Administrative Director as soon as you are aware so alternate internship assignments may be made when matches are drafted.

3. **Preceptor approval:** Agencies must annually submit applications for PM preceptors to their assigned Hospital EMSC/Educator. Candidates are reviewed and approved based on eligibility and performance criteria in Policy P-1. Contested applicants are discussed with the PEMSC, hospital EMSC and PM LI. Persistent differences of opinion are elevated to the Chief, Program Director, and EMS MD.

4. **Field Internships:** PEMSCs shall work with their preceptors to counsel and mentor PM students employed or sponsored by your agency. This includes prepping the student for, and signing all paperwork prior to, phase meetings in compliance with Program policy to ensure that all objectives have been achieved prior to making a recommendation for final action. Work with the student and Program LI to craft corrective action plans as necessary. Inform the Program LI as soon as a sustained performance gap or lack of patient contacts is identified, especially if it appears that the student will not finish on time.

5. Inform the Program Clinical Coordinator if any student appears to need additional hospital clinical time to improve skill competency.

B. **Peer I-IV educators:** Each System agency agrees to assist with identifying and mentoring Peer educators for their agency. **See System policy P7 Peer Educators (1 and 2 only)** and **criteria for Peer I – IV educators** (attached)**.**

C. **Continuing education (CE) In-Station program**

1. 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 and QI data.

2. Since 1981, System chiefs/administrators have voted that core Paramedic CE be provided through the In-station program. A System educator travels to each provider agency on standing days and times based on an agency's request and the program's capacity to comply with that request. Classes are generally conducted while personnel are on-duty. At the present time, we conduct over 95 classes/month; 10 months per year. The **CE academic year spans from July 1 to June 30** with no classes (other than make-ups) scheduled in June or December. Agencies may provide EMT CE and/or supplemental ALS CE internally but must submit a **site code request** in compliance with EMS Rules to the EMS Administrative Director for review and approval before forwarding to the IDPH Regional EMS Coordinator for state approval before it can count toward relicensure hours. See **Policy C2**: Continuing Education.

3. All lesson plans, educational reference materials, handouts, AV aids, consumable med-surg supplies; and class credit questions for Instation classes are prepared by Resource Hospital EMS educators. Handouts are printed by NCH. Class materials are distributed to Hospital EMSCs/educators, Agency Peer IV educators, and approved independent contractors who meet Peer IV criteria who assist in teaching the classes. Each Hospital educator with more than one System agency assigned to them conducts a minimum of 7 classes per month. Many do far more than that as a contribution to the program. The remaining classes are conducted by the Resource Hospital IS educators, independent contractors, and the Administrative Director as time allows.

4. The **budget for the in-station program** is prepared by the Administrative Director and approved annually by the chiefs/administrators. At the request of the chiefs, the Instation fiscal year runs May 1st to April 30th. The budget is broken down into fixed and variable costs paid by all EMS agencies, with each line item listed so all System members know exactly what they are approving. Revenues support the salary and benefits of the 1.5 FTE IS educators hired by NCH specifically for the program, independent contracted educators and 33% of the part-time EMS secretary. It does not cover the salaries of the Agency Peer IV educators, Hospital EMSCs/educators or the EMS Administrative Director who conduct classes. **See Budgeting for EMS handout.**

5. **Scheduling criteria**

   a. **Number, dates and times of classes:** Agencies may request classes to be held M-F during am or pm time frames. There are very few evening classes and only based on extenuating circumstances such as a large number of paid on call members. Contact the System CE Coordinator to change the standing number, dates, or times of classes.

   b. **Location of classes:** Agencies are asked to provide a classroom environment that is quiet and conducive to learning with working AV equipment that allows for the clear projection of PowerPoint slides, internet connectivity, and adequate space for skills labs. Please inform the educator at least two hours in advance as to where the class will be conducted if changed from its usual location.

   c. **Equipment needs:** Classes often have a practical component and cardiac arrest management is competencied every year. Agencies need to have a working CPR manikin that can be connected to an ECG simulator. They need an intubation training manikin that is in good repair and can be used for simulated intubations using King Vision videolaryngoscopy and insertion of a King LTS-D airway. It is helpful if they have a cricothyrotomy training manikin. The CE module author will send notices out in advance if equipment is needed from the agency for a particular class.

   d. **Scheduling change requests:** The majority of the CE schedule is cyclical based on standing classes. Major holidays (Memorial Day, 4th of July, Labor Day, Thanksgiving, Christmas) will alter the schedule in that month. **Calendars** should be issued one month before the classes are to be conducted. Requests for changes must generally be submitted to or requested by the CE Coordinator by the 4th Friday two months prior to the month in which the request occurs. For example, requested changes in Sept must be submitted or agreed to by July unless an unexpected emergency occurs requiring a last minute change.

      Changes to standing CE class dates, times, locations or number of classes must be provided in advance to the CE Coordinator to ensure that the change(s) are incorporated into the master schedule and effectively communicated to the System.

   e. **When submitting requests via e-mail, include the word "schedule" or "request" in the subject line. When adding additional requests to a previous request, send the previous request along with any new or additional requests in the e-mail (so the scheduler knows that they are in addition to vs. in place of previous requests).**

6. **Situational emergencies and inclement weather**

   a. It is the intent of the NWC EMS to conduct business as usual and according to published schedules at all times, including during most periods of inclement weather.

   b. However, the NWC EMSS recognizes that inclement weather and other personal emergencies may occasionally affect a Provider Agency's ability to host CE and/or an educator's ability to get to teaching assignments necessitating a change in class dates and/or times.

   c. Educators and providers are asked to **use common sense** and make their best assessment of the safety and practicality of the situation. No pressure is extended from the System on any educator or agency to take unsafe chances to hold a class. **The safety and well-being of our educators and Providers is of paramount importance in all situations.**

   d. Under these circumstances, System members are asked to be patient and understanding and work together to craft the best plan B. If a trend in last-minute class cancellations is proving problematic, please contact the CE Coordinator or EMS Administrative Director to review the situation and create an action plan acceptable to both parties.

e. Whenever possible, decisions to change normal operations should be made at least two hours before a scheduled class start time and before classes are cancelled.

The CE Coordinator may work with the educator and agency to attempt to get another person to cover the class or may agree that a renegotiated date and time is the best course of action. Cell phone contact numbers are published to the educators.

f. While no policy can cover every potential emergency, these provisions are meant to generally apply to circumstances in which the host agency and/or educator experience an unexpected emergency and/or travel advisories are issued due to inclement weather. Examples may include, but not be limited to the following:

(1) The educator cannot travel safely to the teaching assignment.
(2) Layers of ice make driving and/or walking hazardous
(3) The outdoor temp is so low that public schools are closed (which may pose a problem if the educator has a small child or dependent elder at home) and any time temps are potentially dangerous if the educator were to experience a vehicle malfunction enroute.
(4) Flooding affects the educator or agency.
(5) The governor declares a weather emergency and asks people to stay off of the roads

g. **Examples of situational emergencies include, but may not be limited to the following:**

(1) Urgent situation involving the host agency, educator, or an immediate family member that requires the educator's presence
(2) Death of an educator's family member and/or funeral of an Agency member or person of interest to the agency that requires attendance by a large number of agency members
(3) Home and/or agency disruption to structure; utilities etc.

7. **CE Class content and logistics**

a. Educators shall conduct CE classes using methods and materials as designed and prepared by the Resource hospital educators. It is vitally important to maintain as much consistency as possible between CE offerings even though conducted by multiple educators.

b. All content presented must be aligned with National EMS Education Standards, current high quality and reliable literature, SOPs, EMS policies, Procedures, System memos, practice alerts and CQI findings. If practice questions arise that are not clearly understood or documented in policy or protocol, forward to the EMS Administrative Director and it will be answered by the Resource Hospital team of the EMS MD, EMS Admin Director, and CE Coordinator with general distribution to the System if applicable.

c. **Classes in which new mandatory skills are being introduced or practical exams are being conducted are limited to a student instructor ratio of 10:1** unless an exception is announced/approved by the Resource Hospital in advance.

8. **Missed content and reschedules**: **See Policy C-2.**

a. Classes are designed for last 2 hours with no break time included, but each class is given a 3 hour window within which class activities are to be accomplished given frequent interruptions for calls.

b. If interruptions cause attendees to miss more than 30 minutes of content, they have multiple makeup options: complete the class credit questions for the information missed or attend that portion of another class for full CE credit; or attend an ECRN, TNS, or PM class covering that content.

c. If a class is not ready to start within 45 minutes of the scheduled start time, it may not be finished as designed if any calls or breaks occur and may be canceled for that day unless the educator and the officer on duty mutually agree that class will go over by the same time frame that it is delayed in the beginning. Content shall not be cut or omitted to get the class done on time.

d. If the educator has other commitments, they are not obligated to end a class late (beyond the three hour window). If the educator must leave after 45 minutes, it is with the understanding that the makeup class must be scheduled at the mutual convenience of the agency *and* the educator.

e. If class is started, but all participants must leave for over 45 minutes, the class must be rescheduled unless all parties are willing to stay and conduct the class in its entirety.

9. **Documenting and awarding CE credit – See C2 policy for specific details**

a. EMS agencies must ensure the availability of annual CE Didactic forms at class for all participants. Educators shall verify each person's attendance in colored ink (not black).

b. As a check and balance, CE rosters shall be brought by the educator to the class and signed by all attendees. Educators need to document on the CE roster the time and class content missed by each participant so accurate CE time can be awarded and made up appropriately.

c. Copies of the roster are to be distributed as indicated on the form.

d. If an agency does not have their CE Didactic forms at the location where class is held, the educator shall make a bold notation on the roster so the PEMSC and Hospital EMSC/Educator are made aware.

e. If a participant attends a class at an agency/hospital as a guest, the educator shall complete a CE form (½ sheet) and distribute as indicated on the form.

10. **MANDATORY CLASSES**: The System must have an accurate accounting of those who miss a mandatory class and appropriately schedule make-up classes. See **Policy M2: Mandatory Reviews.**

a. All System members are of equal standing for mandatory reviews. It does not matter if the NWC EMSS is their primary or secondary System. They must all complete mandatory classes within the policy parameters.

b. Provider and hospital EMSCs shall account for personnel who missed a mandatory class after the last offering of that class in the System.

c. Agency leaders are asked to help in getting all personnel to one of the regular offerings to minimize the need for makeup classes. Hospital EMSCs should be informed by their PEMSCs regarding those who missed a mandatory class.

Make-up classes

d. The System attempts to coordinate make up classes on each shift. Class size may be limited based on the material to be covered and/or the skills to be performed in keeping with usual and customary student/instructor ratios. **All participants must call the hospital EMSC in advance to confirm their attendance and to confirm space availability.**

e. ECRNs shall not displace guest PMs in attending a mandatory make-up class at an EMS agency if the PM called in advance to confirm their attendance. ECRNs and guest PMs shall not displace PMs from the host agency for classes with limited instructor/student ratios if the ratio would exceed 1:10 due to the presence of guests.

f. The System may extend the makeup period for extenuating circumstances (e.g., veterans returning from deployment, members returning from LOAs).

g. Educators are asked to not schedule individual make-ups for mandatory classes unless extenuating circumstances apply that are discussed in

advance with the EMS Administrative Director. If additional classes are scheduled, we prefer to post them so others may also attend.

h. If no or insufficient participants have signed up 24 hours prior to the class, it may be cancelled by the educator with notice to the CE Coordinator. Cannot do pit crew approach to cardiac arrest management with 2 people.

11. **REVIEW and VERIFICATION OF ANNUAL CE HOURS and Mandatory Competencies – See C2 policy**

a. **Timing of record reviews:** All annual CE hours and mandatory competencies must be completed and documentation reviewed and affirmed by the designated PEMSC and hospital EMSC/educator by June 30 each year. CE hours may be reviewed more frequently if the designated hospital EMSC/educator opts to do so.

b. Each hospital EMSC/educator will work with their assigned PEMSCs to jointly review and affirm completion of CE hours, CPR cards, and verify airway competencies, blood-borne pathogen and safety education, and restraint competencies. Any deficiencies shall be noted and submitted in writing to the PEMSC. The PEMSC is responsible for forwarding this notice to the EMS professional that their annual requirements are met or not met. If unmet, the notice shall also include policy information regarding submission of credit questions and assessed late fees.

VIII. EMResource View-Only Access for EMS and 911 Dispatchers

A. IDPH is responsible for gathering and monitoring hospital status information along with resource availability and capacity data. It fulfills this responsibility using a hosted information system called EMResource. Hospitals provide this information to IDPH based on an understanding that it will be only be used for public health and healthcare emergency preparedness and response purposes.

B. IDPH recognizes that EMS providers and 911 dispatchers may benefit from having access to this information, especially during public health emergencies and other situations involving a spike in demand for hospital resources that may lead to increased **bypass** activity. IDPH further recognizes that EMS and dispatch organizations understand that they are being given EMResource access to improve situational awareness and will not take any action based solely upon information obtained from the system.

C. System users should remain cognizant of the fact that information in EMResource is updated at different times and may not reflect hospital status in real time. IDPH therefore agrees to provide personnel employed by the organization who submit applications (form on System website) with view only access to EMResource, subject to written confirmation that **information obtained from EMResource will:**

1. Be used solely for emergency response purposes, or activities directly related to preparing for a response such as planning, training, and exercises;
2. Not be released to the media, other agencies, or to the general public;
3. Not be used for research without the express permission of IDPH.

D. For more details contact Dan Lee at IDPH. To **access the application form contact the EMS Administrative Director**. All signatures must appear before the request will be considered. Once complete, scan and send the form to Connie Mattera for System signature. She will forward to daniel.lee@illinois.gov for processing.

IX. EMS PERSONNEL FILE CONTENTS & PROCESSING; Letters of verification

A. The System is responsible for maintaining files on all current and former students (per statutory or regulatory requirements) and EMS personnel files on all active, inactive, and former EMTs, PMs, PHRNs, and ECRNs. Student files shall remain at the Resource hospital. Active PM, PHRN, and ECRN files shall be located at the assigned System hospital or where the ECRN is employed. All EMT files shall be maintained by the Agencies.

B. An active **PM/PHRN file** shall be initiated by the Resource Hospital and forwarded to the assigned EMSC/educator as soon as System privileges are awarded. Agencies shall initiate and maintain active files for their own EMRs and EMTs. **Files shall contain at a minimum:**

1. **Demographic information** that includes at a minimum the person's name, address, phone number, e-mail address, System employer, primary and secondary System affiliations if applicable; DOB, social security and driver's license numbers.
2. Copy of current IDPH license
3. Copies of system entry paperwork (if applicable) that will include a Letter of verification from their most recent EMS system if not educated in the NWC EMSS.
4. Copy of current annual CPR card for healthcare provider (front/back)
5. **PM/PHRN:** Letter from NWC EMSS authorizing ALS practice privileges
6. CE hours accrued in the current and previous licensure periods, including CE certificates from offerings conducted outside of the NWC EMSS
7. Coaching notes; praises; sustained complaints with corrective action plans
8. Inactive/suspension/reinstatement/extension request letters
9. Copies of certificates of merit, service anniversary certificates/letters
10. Anecdotal notes to the file

C. **Non-System members:** If an EMR/EMT/PM/PHRN/ECRN has no current affiliation with a NWC EMSS hospital or provider agency, the System has no legal jurisdiction over their practice privileges or license. Files of former PMs/PHRNs shall be archived at the Resource Hospital. The System will not hold active files, monitor CE hours, nor re-license any person who is not a current system member in good standing unless extenuating circumstances apply and approval is granted by the EMS Administrative Director.

D. **Letters of verification:** If a system member needs a letter verifying EMS privileges in the NWC EMSS, the assigned hospital EMSC/educator is authorized to create the letter using the System-approved template for that year and forward to the EMS System specified by the EMT/PM/PHRN/ECRN. A copy shall be placed along with the date sent in the person's EMS file. If a former System member requests a letter of verification after leaving the System and the file has already been returned to the NWC EMSS, the EMS Administrative Director will review the file and send an appropriate letter.

E. For additional information on purging information or releasing information from files, refer to **System Policy R-2 Review and Maintenance of EMS Personnel Files**

X. **EMS PERSONNEL LICENSES –** See Policy R-1 RELICENSURE/REINSTATMENT/Dropping to lower level of licensure: EMT/PARAMEDIC/PHRN last updated 9-1-17

A. Each PEMSC should have an electronic file with the names, license numbers, last known address, and license expiration date for each of their members so they can keep track of who is due to renew and when.

B. IDPH will mail a **renewal notice** to each licensee at the last known address in the state database at least 60 days prior to expiration. Address changes must be made ON LINE by the individual in the IDPH database listed below. If the person's name, address or other information is incorrect, this can cause the renewal notice to be undeliverable.

C. The renewal notice contains a **PIN #** that is needed to renew the license online. This is the easiest way to renew and can expedite processing time. Notify the EMS Admin Director if the notice has not been received 60 days prior to the license expiration date and she can provide you with the individual's PIN number.

D. **Name changes** must be processed with the IDPH EMS Division per the mail, submitting copies of legal documents acceptable to IDPH that verifies the name change. Contact the IDPH Springfield office at 217-785-2080 to get information on changing a name.

E. **Renewal STEPS:**

1. To renew ON-LINE - GO TO: https://emslicensing.dph.illinois.gov/Clients/ILDOHEMS/Private/OnlineServices.aspx
2. Select renew license (if current licensee) or Pay INITIAL fee (if new PM)

3. Answer the felony conviction and child support questions
4. The Northwest Community EMS System number is 0907.
5. Pay fee by credit card. The software is programmed to charge the correct fee.
6. Once the individual has completed their part of the renewal process they should contact their PEMSC.
7. The **PEMSC will then contact the EMS Administrative Director** (Connie Mattera) by e-mail. (cmattera@nch.org). Include the licensee's **full name, license number and expiration date** so they can be matched in the state database.
8. If up to date with CE hours and mandatory license requirements, the EMS Admin Director will complete the process of license renewal in the state database. If delinquent in CE or license requirements, a licensee cannot be renewed.

   Updated licenses will be mailed by IDPH to the licensee address entered during the renewal. If other than the employer's address, the employer must get a copy of the license from the licensee for their records.
9. **It is essential that every licensee understands these requirements.** IDPH holds each **individual responsible** for maintaining their IDPH license and renewing it on time. The System's role in the renewal process is only to affirm that CE hours are complete and verifiable. The System is not responsible for providing alternate notice that a licensee is due to renew or to organize CE submissions into a reviewable document.
10. **LATE FEE**: If the renewal information and fees are not received by IDPH before the license expiration date, but are received within 60 days after that date, the individual will be assessed an additional $50 late fee by IDPH that must be paid before the license will be renewed. An individual may not function in a medical capacity after their license lapses until the date of renewal.
11. If renewals are received later than 60 days after the license expiration date, the lapsed licensee will have to go through a process of **reinstatement** that includes remediation, retaking the state exam, and paying a reinstatement fee of $60.

XI. EQUIPMENT/SUPPLY RESOURCE MANAGEMENT

A. EMS drugs, equipment and/or supplies are researched and recommended by the **Research and Development Committee** and approved by the EMS MD. All agencies are invited to participate on the R&D Committee that meets every other month on the 1st Wednesday after PBPI (See website for upcoming meetings).

B. Monitor and insure that all EMS vehicles and equipment are present and in good working order. Notify the EMS MD and immediately remove an item exactly as configured at the time of an incident per **M-8 Medical Device Failure/Malfunction** if a malfunction occurs.

C. Ensure an adequate inventory of all EMS drugs/supplies/equipment **in compliance with the current System Drug and Supply List** unless a general shortage is being experienced.

1. If any item cannot be provided in compliance with standards and a contingency plan is not already in place, notify the EMS Admin Director via e-mail explaining your situation. If the problem is unique to your agency, submit a Variance request outlining the cause of the temporary inability to comply, stating the action plan to rectify the problem and identifying a projected compliance date. Variance requests will be considered by the EMS MD on a case by case basis and may or may not be granted based on the nature of the request.
2. **Agencies may NOT add or substitute alternative EMS products/ manufacturers without prior System authorization.**
3. If any item on the Drug & Supply List is not available for exchange at a receiving hospital, special inventory management procedures must ensure the availability of restock supplies or viable alternatives. The System will issue practice alerts or System memos outlining steps to take with known shortages.

4. **Controlled substances** must be stored and monitored per System policy **C-6 (Controlled Substances on EMS Vehicles)**.
   a. PEMSCs are responsible for monitoring the accurate completion of Controlled Substance logs to be submitted by each agency to their assigned hospital EMSC/ educator on a monthly basis.
   b. If the logs are incorrectly completed, contact the appropriate crew members to correct the problem immediately and prior to submission of the logs to the assigned hospital EMSC/educator for archiving.
   c. Logs shall be stored in compliance with each hospital's DEA procedures. For more information see System Policy C-6.
   d. If an agency experiences a **discrepancy in drug counts** contact the EMS Admin Director. If a discrepancy cannot be reconciled within 24 hours **(loss, theft, or missing controlled substances)**, it must be reported to the EMS MD and possibly the DEA in addition to completing a Request for Clarification and police report as applicable. Go to https://apps.deadiversion.usdoj.gov/webforms/dtlLogin.jsp
   e. The EMS Admin Director can assist the PEMSC in identifying components that must be included in their local investigation. The link to the DEA website contains information on DEA form 106 used to report loss of controlled substances. Reporting is required for "significant loss" or "theft". The EMS MD needs to assist in filling out the report as a DEA # is required.

D. **Disposable supplies** shall be supplied by the assigned System hospital for new ambulances, non-transport, and alternative response vehicles included in an agency's System plan.

E. PEMSCs shall facilitate the transition of ambulance inventory stock when the System Drug and Supply List is updated in compliance with System policy. **D3: APPROVING / ISSUING / EXCHANGING DRUGS & SUPPLIES.**

XII. FORMS/DOCUMENT MANAGEMENT

PEMSCs are responsible for accessing and/or making available *current* EMS documents and selective forms that may be used by EMS personnel including, but not limited to, the following:

A. Controlled substance logs
B. Paper copy refusal forms
C. Child Abuse Reporting form (DCFS)
D. Relinquished newborn forms and paperwork (IDPH)
E. EMS SOPs, access to policy manual and procedure manual at each ambulance quarters
F. EMS Renewal notice: (current copy from IDPH website)
G. IDPH forms to request Inactive status; Reactivation; Reinstatement (IDPH website)
H. EMS Training Program Application (Site Code Request form) (IDPH website)

XIII. INSPECTIONS/LICENSES (Vehicles)

A. One of the two Northern Illinois Ambulance Inspectors will contact each agency to schedule annual ambulance inspections.

Emily Doering: (630) 293-6811; email: Emily.doering@illinois.gov; cell: (630) 441-3771
Louise Roberts RT, BS, MPH; e-mail: louise.roberts@illinois.gov
Illinois Department of Public Health Division of EMS and Highway Safety
245 West Roosevelt Road, Bldg #5
West Chicago, Illinois 60185
Office: 630-293-6816 Cell: 630-723-7225 Fax: 630-293-6908

B. **Transport Vehicle annual inspection notice**: If providers have not heard from either state inspector by 30 days before inspections are due, contact Louis Roberts.

C. **Ambulance inspection standards** to be applied. The EMS Act (210 ILCS 50/3.85(b) (8) and the EMS Administrative Code, 77 Ill Adm. Code 515.830(a) and 77 Ill Adm. Code 515.125 (2) (a) govern ambulance design standards. Federal Specifications for the Star of Life Ambulance https://www.ok.gov/health2/documents/KKK-A-1822F%20%2007.01.2007.pdf is STILL THE ILLINOIS STANDARD.

1. Any ambulance: (i) purchased; and (ii) placed in service under KKK-A-1822 E and has continuously remained under the same ownership, will be inspected using the E standards unless or until the vehicle's ownership changes.
2. If any ambulance placed into service under the KKK-A-E standard changes ownership after the KKK-A-1822 F standard took effect (2007), then that ambulance will be held to and inspected under the KKK-A-F standard. Any ambulance held to the KKK-A-F standards that has **markings not in compliance** with KKK-A-F will require a waiver from that PROVIDER that will be reviewed on a case by case request.
3. Any new vehicle purchased after 2007, will be held to and inspected under the KKK-A-1822 F standard (Leslee Stein-Spencer correspondence 6-18).
4. **BLS** portion of inspection: Completed by state inspectors on state forms every year.
5. **ALS** portion of inspection: Completed by System members – see below
    a. ALS ambulance inspections are done by the assigned **hospital EMSC/educator every other year**. PEMSCs shall contact their designated hospital EMSC when a date and time has been set up for the BLS inspection with the state rep to see if they can do the ALS portion at the same time.
    b. **Providers may do an ALS self-inspection on the alternate years** using the System's current Drug and Supply List (ALS portion only)
    c. Carefully note the Agency name, complete ambulance VIN number, and license plate number on the inspection forms. Even 1 number or letter difference between the form and the state database will delay the ambulance approval.
    d. **Caveat**: Hospital EMSCs may do random unannounced inspections during the self-inspection year. If discrepancies are found, the hospital EMSC will inspect all ambulances during that year.
    e. **New vehicles:** Self-inspections are not authorized for new vehicles. Schedule the BLS and KKK spec portion with one of the state inspectors. The assigned hospital EMSC must do the ALS portion as above.
    f. **System Modification (Sysmod) form**: Any change in vehicle level of service (ALS/BLS), status - going out of or into service, moving from one address or System to another, changing license plates from one vehicle to another, etc. requires an IDPH Sysmod form. Blank forms are posted on the IDPH EMS website. An authorized member of the Provider Agency must sign the form and send to the EMS Administrative Director to approve on behalf of the System. She will return the form to the PEMSC and forward to IDPH.

D. **Replacement vehicles: Section 515.830 Ambulance Licensing Requirements** l)

A licensee may use a replacement vehicle for up to 10 days without a Department inspection provided that IDPH is notified of the use of the vehicle by the second working day. The substitute ambulance must have been inspected within the last year, have a current safety sticker and an IDPH license. Submit a complete ambulance inventory attesting that all NWC EMSS-required drugs and supplies have been transferred to it so EMS personnel have full access to our required standards. Submit a System modification form to the NWC EMSS Office Administrative Director indicating the vehicle name, agency to which it is registered, license plate #, VIN # and date place in service.

E. **Non-transport vehicles (Med Engines)**

1. For State Regulations see the **EMS Rules Section 515.825 Alternate Response Vehicle.** Also see System policy M9 MedENGINES; Alternate response NT vehicles

a. Non-transport vehicles are dispatched prior to dispatch of a transporting ambulance. These vehicles include ambulances and fire engines that contain the staff and equipment required by this Section. The vehicle service provider shall identify these vehicles as a program plan amendment (System modification form submitted to the EMS Administrative Director) outlining the type and level of response that is planned. These vehicles shall be staffed 24 hours per day, every day of the year.

b. ALS/ILS non-transport vehicles. These vehicles shall have a minimum of either one PARAMEDIC, or one EMT-I and one other EMT, and shall have all of the required equipment.

c. BLS non-transport vehicles. These vehicles shall have a minimum of two EMTs and have all of the required equipment.

d. Issuance and renewal of license: Upon payment of the appropriate fee (to IDPH), qualifying non-transport providers shall be issued a provider license that lists a number for each level of care approved. Licenses will not be issued for individual non-transport vehicles. Providers shall inform the EMS System and the Department of any modifications to the application, using the System Modification forms (sys-mod). Licenses will be issued for one year and will be renewed upon completion of the self-inspection.

2. Agencies may self-inspect all BLS and ALS NT vehicles for renewal using the System M-9 (MedEngine) policy for the ALS components and the State Form for the BLS components. As above, hospital EMSCs/educators may do random unannounced inspections. If discrepancies are found, the hospital EMSC/educator will inspect all NT vehicles during that year.

3. **All non-transport vehicle inspections and license renewals in the NWC EMSS are due in September of each year** (because we are in Region 9).

4. **Agency Non-transport number (put on inspection form)**

   Since April 2016, each agency has only one EMS number. Add-on letters to the Transport License Number signify the type of provider services licensed by IDPH for that provider. Example: A Non-transport vehicle license number is the Agency's provider number (**1st four digits of their license plate) plus the letters NT.** Thus agency 1234 will use 1234NT for all non-transport vehicles.

F. **Fees**: Fees shall be mailed by the Provider Agency directly to the Accounting Office in Springfield to the address on the bottom of the cover letter. They should NOT wait until the inspection is done to mail the check to IDPH.

G. **Waivers:** Equipment waivers must be requested and approved annually. If a waiver is approved, attach to the inspection form (unless a System-wide waiver exists). If there is a System-wide waiver (e.g., backboards on MedEngines, baby bottles on anything), write SWW in CAPITAL LETTERS on the form over that piece of equipment. If the waiver is specific to your agency only, write a capital W over the name of the equipment.

H. Provide a current agency personnel **roster** listing names, license numbers, level of licensure, and license expiration dates with all inspection paperwork. Affirm all licenses are current. An incorrect or incomplete roster can delay ambulance relicensure.

I. Forward completed inspection forms, roster, and Sys-Mod form (if necessary) to the EMS Administrative Director for processing with IDPH. The ambulance license will be processed when IDPH matches all required paperwork with the license renewal fee payment.

XIV. PLANS – Program and Strategic

A. Agency Plans/AGREEMENTS – See policy P5 System Plan Agreements

1. PEMSCs are responsible for submitting their agency's EMS Plan Amendments when updates are necessary. Plan modification notification (e-mail is fine) are required for changes in the following
   a. Agency name
   b. Leadership changes: Chief/EMS CEO; Provider EMS Coordinator
   c. Vehicles: Number, level of participation (ALS or BLS); service areas
   d. Dispatch agency
2. IDPH will provide a template and cover checklist to facilitate the process when the overall plan must be updated per IDPH request.

B. **System EMS Strategic Plan**: Approved annually by the System Advisory Board and Chiefs/ administrators with input from all standing committees. Directs and guides all EMS activities. See System website under Standards of Practice tab.

1. Updated annually to include a 5 year planning horizon
2. Includes the System mission, vision, and values statements
3. Provides an overview of the history, national statutes, standards, guidelines, and models that guide modern EMS in addition to strategic priorities for the year.

XV. QUALITY MANAGEMENT

A. **Provider Based Performance Improvement (PBPI)**: The System is committed to excellence and operating in compliance with evidence-based guidelines whenever possible. The PBPI Committee has been chartered since 1991 with membership from all System hospitals and agencies. They create and implement the Systems' annual Performance Improvement Plan (**See System website under PBPI and the Continuous Quality Evaluation and Improvement pages of the EMS Strategic Plan**).

To achieve our goal of effective measurement and improvement, agencies are asked to provide monthly process and/or outcome data as stated in the PBPI plan. Turn-around time on requested information shall be reasonable and mutually defined. Please ensure that your PBPI rep accurately provides the requested data by the stated deadlines so the System is able to generate valid reports using a population that reflects the entire System and is sufficiently powered to reach statistically sound conclusions.

B. **Patient run reviews and coaching notes**

1. Each PEMSC and hospital EMSC/Educator is asked to review ePCRs for agencies within their span of control. They shall evaluate reports for accuracy, completeness, and timeliness of assessment, care, and documentation as measured against System standards of practice.
2. Feedback shall be provided to the EMS crew and/or the PEMSC and EMS Administrative Director using a form and/or method that allows praise for excellent performance or to point out opportunities to improve and to track the EMS agency response to feedback. See note on confidentiality below.
3. If the hospital EMSC expects a response from EMS personnel and does not receive one within 15-20 days, they shall contact the PEMSC and also inform the Agency Chief/EMS CEO and the EMS MD.

C. **QM confidentiality**: All information contained in or relating to any medical audit performed by the EMS MD (or his designee) of care rendered by System personnel, shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure. Disclosure of such information to IDPH shall not be considered a violation of that Code. **Please make the following notation on all Requests for Clarification (RFCs), Run Feedback Forms or notes, and/or coaching notes:**

PRIVILEGED AND CONFIDENTIAL - PEER REVIEW DOCUMENT - PATIENT SAFETY WORK PRODUCT. Protected under the Patient Safety and Quality Improvement Act. Do not disclose unless authorized by the NWC EMSS EMS MD or his designee.

"This report is not part of any patient's permanent medical record. All information provided, including any appended materials, is furnished as a report of quality management and is privileged and confidential, to be used solely in the course of internal quality control for the purpose of reducing morbidity and mortality and improving the quality of patient care in accordance with Illinois Law (735ILCS 5/8-2004 et seq)."

Do NOT file or store QI-related notes or documentation near or with the PCRs to avoid inadvertent disclosure.

XVI. **REPORTABLE INCIDENTS: See System Policy R-7 Reportable Incidents** for details regarding reporting obligations and processes. If the concern is tied to a Medical Device Malfunction or Failure also see Policy M8: Medical Device Failure. If due to missing controlled substances, see these guidelines on page 12.

XVII. **REQUESTS FOR CLARIFICATION** (RFCs)

A. Anyone may file a Request for Clarification. See **System Policy G-1 Grievance Policy and D-1 Due process rights** and reporting obligations. The suggested RFC investigation form is offered to facilitate follow-up. An RFC may also be initiated after a Reportable Incident occurs. No action shall be taken on anonymous complaints unless made to the State complaint hotline and IDPH requests that the System do an investigation.

B. **Preliminary considerations if a complaint is filed**

1. Any immediate concerns to be addressed prior to commencing a full investigation.
2. Is the nature of the alleged misconduct such that the person's continued presence in the class/work place would be inappropriate?
3. Does the person pose a risk of injuring others or compromising sensitive information?
4. Would the person's presence intimidate others who may be asked to give information?
5. Is the person's alleged misconduct so egregious that their continued presence in the work place/class would constitute a foreseeable harm to public safety or negative media coverage?
6. Are there grounds for an immediate suspension/dismissal?
7. Is sufficient information available about this incident and/or similar ones in the past to support proposed disciplinary actions? Consult with other resources as needed.
8. Are there mitigating circumstances that would impact your findings?
9. What are the standards to test? Review all relevant system policies, procedures or protocols to weigh the facts against system guidelines.

C. **Conducting an investigation**

1. When investigating a complaint, talk directly with all parties involved to get their recollection of the facts using the following: (1) focus on the information needed; (2) use open-ended questions to expand the discussion and closed-ended questions to prompt for specifics; (3) encourage communication through eye contact and facial expression; (4) state your understanding of what you are hearing and (5) summarize before closing the discussion (Zenger-Miller).
2. Get their statements in writing.
3. Determine whether the complaint appears to be sustained or non-sustained. If unclear, seek counsel from the EMS MD or EMS Administrative Director. Before any decision that imposes EMS disciplinary action in the form of a suspension is invoked, please discuss with the EMS MD as paperwork must be filed with IDPH. Suspension/dismissal is a defamatory act and one must have reasonable grounds to warrant such action per System policy and IDPH EMS Rules. Suspension/dismissal must be considered against prior practices and the informal and formal policies of the System to ensure that they are not being administered discriminatorily.
4. It is essential to maintain a "paper trail" documenting all investigations and complaint resolutions. While individual discretion may be used to a certain degree in format, **the following minimum elements must be present in the final written report:**

a. Date, time, and location of incident and date complaint filed.
b. Person making complaint; and call back number.
c. Complaint/allegation/situation needing clarification.
d. Facts determined, root causes, and any mitigating circumstances.
e. Suggested resolution and corrective action plan, if applicable.
f. Disciplinary action recommended, if applicable.
g. Policy revision recommended, if applicable.
h. Consultations made during course of investigation.
i. System leaders notified if a reportable incident (EMS MD, Ad. Dir., Chief).
j. Date matter closed; signature of primary investigator.

XVIII. SIGNIFICANT EXPOSURES TO BLOOD AND/OR BODY SECRETIONS

A. Each agency shall name at least one designated infection control officer **(DICO)** and inform the EMS Administrative Director if the name or contact information for their DICOs changes.

B. Each hospital is responsible for appropriately following up per system policy after a possible exposure event based on the request of the agency DICO.

C. See System **Policy I-2 Infection Control Measure**s/Communicable Disease Follow-up for more details.

XIX. SPECIAL EVENTS: See policy E6 EPISODIC MASS GATHERING EVENTS

A. IDPH requires submission of an **EMS Systems Special Events Request Application Form** (IDPH website) to be completed as an amendment to an existing EMS system plan by the EMS provider agency that will be providing on-scene coverage at a specific event.

B. The completed form and attachments, if appropriate, should be forwarded to the EMS Administrative Director for review and approval by the EMS MD. If approved, the EMS Admin. Director will forward the signed form to the IDPH Regional EMS Coordinator for state approval.

C. Signed forms shall be submitted to IDPH at least 45 days prior to the event.

D. The System will act as a resource for maintaining the standard of care at all events located within the geographic boundaries of the NWC EMSS regardless of size.

XX. STANDARDS OF PRACTICE

A. The following provide the basis of the System's standards of practice and must be thoroughly understood and complied with by all System members:

1. National **EMS Scope of Practice model** and **EMS Education Standards** as adopted by IDPH, Region IX and the NWC EMS MD.

2. **NWC EMSS Standard Operating Procedures:** Evidence-based patient care protocols achieve best practice outcomes. All SOPs are based on current national research/guidelines and the National Model EMS Protocols**.** They are updated at least every 2-3 years by Region IX. Full-size copies are printed by the Resource Hospital and distributed at no cost to provider agencies or hospitals. They should be available at each ambulance quarters. The document is posted to the website under the Standards of Practice tab. Reduced size copies are printed when the SOPs are updated and are available for purchase.

3. **NWC EMSS Policy Manual**: All System policies are discussed and approved by the EMS Advisory Board. Any policy requiring monetary outlay by Provider Agencies must also be approved by the Chiefs/administrators. Policies provide direction on issues supplementary to the SOPs. The manual is expansive and reflects best practice models based on current statutory and regulatory requirements and industry standards. Policies are posted on the System website under the Standards of Practice tab. PEMSC's shall ensure that a current edition of the manual is accessible at each ambulance quarters for reference by EMS personnel.

4. **NWC EMSS Procedure Manual**: Skills are discussed by standing Committees and recommendations/input are welcome from System members. The Procedure

Manual is posted to the website and serves as the official guideline on how all procedures are to be performed in the NWC EMSS. Do not vary from the steps as outlined in this document when providing education/coaching or competency measurement. To suggest a change to any procedure, contact the EMS Admin Director and your suggestion will be forwarded to R&D and the EMS MD.

5. **System Drug and Supply Lists** for transport and non-transport vehicles

6. **System memos, education updates and Practice Alerts:** Update or clarify standards. Documents are distributed electronically and posted to the website. PEMSCs are responsible for making sure all EMS personnel are informed when these documents are released.

7. **Emergency Preparedness**
   a. The Region plan is available from Sherman Hospital. Specifics are included in the SOPs.
   b. Start and JumpStart triage and SMART tag use is specified in System SOPs and education materials (last presented Feb. 2018).
   c. Agencies are encouraged to participate in multijurisdictional planning and exercises.

XXI. STATISTICS and DATA

PEMSCs may be requested to participate in special projects requiring data collection, tabulation, and/or analysis as the need arises.

XXII. SUSPENSIONS – See Policy D-1 (Due Process: System Participation Suspensions)

A. Intent to suspend notices shall be generated by the EMSCs/educators to members of their assigned agencies using a form issued by the System and sent by dates agreed to each year to those who are noncompliant in meeting a System requirement.

B. Notices suspending EMS privileges due to persistent non-compliance with System requirements after the warning notice shall be generated by the EMSCs/educators using a form issued by the System by the date requested.

C. Copies of suspension and reinstatement notices must be forwarded to the EMS Admin Director and PEMSC when issued so the members' status may be changed in the Image Trend database by the PEMSC.

XXIII. SYSTEM ENTRY – See System website for forms and process

A. The practice of EMS is complex, dynamic, and diverse. It is historically built upon the domains of education and licensure. The public is best served when EMS providers receive externally accredited education, are nationally certified, state licensed, and credentialed by the local EMS MD (NAEMT/NAEMSP position statement, 2016).

B. **Passing a state or NREMT Exam does not automatically convey a state license.** Licenses must be recommended by an EMS MD and licensure fees must be paid prior to IDPH awarding any EMS license.

C. While EMTs/PMs/PHRN/ECRNs in Illinois are licensed by IDPH, they must be awarded practice privileges by the local EMS MD. The diversity of clinical and operational protocols, scopes of practice, and equipment used in EMS programs requires local verification of the EMS provider's clinical and operational abilities.

D. **Credentialing involves at a minimum**
   1. Demonstration of sufficient cognitive knowledge;
   2. Demonstration of mature, responsible affective ability;
   3. Demonstrated competency for all involved psychomotor skills; and
   4. Demonstrated ability to integrate the three domains in thinking critically and acting responsibly during the provision of clinical care

E. The NWC EMSS credentialing processes shall be fair, consistent, objective, and based on clearly communicated, evidence-based performance standards that are accessible to any EMS provider seeking clinical credentialing within the NWC EMSS.

F. Also see **System Policy: E-3 Entry into the Northwest Community EMS System**

G. It is helpful if a PEMSC knows that a recent hire will be completing agency-required education or orientation by a particular date and System entry testing is anticipated within an expected time-frame to notify Pam Ross in the EMS Office at pross@nch.org to give us advance notice for planning purposes.

Northwest Community EMS System
Organizational Chart

Steve Scogna
President & CEO NCH

Eileen Gillespie, DNS
Acting Exec VP Patient Services & CNO

Matthew T. Jordan, MD, FACEP----------John M. Ortinau, M.D., FACEP
EMS System Medical Director — Alternate EMS MD

Connie J. Mattera, MS, RN, PM
EMS Administrative Director and System Coordinator
Director, Resuscitation Department
Paramedic Program Director
TNS Course Coordinator

EMS Educators:
Kourtney Chesney, PM (PM class lab coordinator)
Chris Dunn, AAS, PM (EMT LI)
Jennifer Dyer, BS, RN, PM (Educator & PM Clin Coord)
Michael Gentile, BA, PM (Paramedic class LI)
Susan Wood, BSN, PM (CE Coord)

Secretaries: Kathy Fitzpatrick
Pamela Ross

CTC Coordinator: Dara Sordo

EMS Provider Agency Hospital Assignments

Alexian Brothers	Advocate Good Shepherd	Glen Oaks Hospital	NCH ED	NWC EMSS	Resurrection	St. Alexius
Georgene Fabsits	Beth Keane	Lisa Henson	Noreen Unti	J. Dyer - Prospect Heights C. Mattera - Des Plaines S. Wood - Mount Prospect - Lincolnshire RW	Virginia Logan Cindy Brennan	Karin Buchanan
- Bloomingdale - Elk Grove Rural - Elk Grove Village - Fermilab - Itasca - Wood Dale	- Barrington - BCFPD - Lake Zurich - Long Grove - Kurtz/R8	Superior	- Arlington Heights - Buffalo Grove - Palatine - Palatine Rural - Rolling Meadows		- Advantage Amb.	- Hoffman Estates - Schaumburg

Resource hospital contacts:

EMS MD	Matt Jordan	mjordan@nch.org	cell 847-962-6008
EMS Administrative Director	Connie Mattera	cmattera@nch.org	847-618-4485
CE & System Entry Coordinator	Susan Wood	swood@nch.org	847-618-4486
PM Class Lead Instructor	Mike Gentile	mgentile@nch.org	847-618-4490
PM Class Clinical Coord/FISDAP	Jen Dyer	jdyer@nch.org	847-618-4494
PM Class Lab Coordinator	Kourtney Chesney	kchesney@nch.org	847-618-4488
EMT Class Lead Instructor	Chris Dunn	cdunn@nch.org	847-618-4492
EMS Admin supports System; TNS/ECRN	Kathy Fitzpatrick	kfitzpatri@nch.org	847-618-4480| phone 847-618-4489| fax
Supports CTC; System entry/EMT/PM/CE	Pamela Ross	pross@nch.org	847-618-4482
Community Training Center Coordinator	Dara Sordo	dsordo@nch.org	847-618-7403| phone 847-618-7419| fax

IDPH Regions 8 & 9 EMS Coordinator: Joyce McNamara-Coughlin, M.Ed., RN
Illinois Department of Public Health Division of EMS & Highway Safety
Phone: 630-293-6805
245 W. Roosevelt Road, Building 5, West Chicago, IL 60185
E-mail: Joyce.McNamara-Coughlin@Illinois.gov

National Resources

National Highway Traffic Safety Administration (NHTSA): www.ems.gov

EMS Agenda for the Future (1996); **EMS Agenda 2050 (2018)**

DATA

A Leadership Guide to Quality Improvement for EMS Systems
EMS Compass: Developed a process to create performance measures to improve the quality of care at the local, regional, state and national levels.
Addressing Public Health Issues with EMS Data
National EMS Information System (NEMSIS) is a national effort to standardize the type of data collected by EMS agencies; provides the framework for collecting, storing, and sharing standardized EMS data nationwide.

EDUCATION

EMS Education Agenda for the Future A Systems Approach (2000)
EMS Education Standards (2009) and **Instructional Guidelines**: EMR, EMT, AEMT, Paramedic
National EMS **Scope of Practice Model** (2007, 2018)
EMS Core Content (2005)
2002 National Guidelines for Educating EMS Instructors
EMT-P and EMT-I Continuing Education National Guidelines
Advanced Automatic Collision Notification (AACN) Training Course for EMS and 911 Medical Directors
1996 Emergency Medical Dispatcher (EMD)
1995 Emergency Vehicle Operators Course (Ambulance) Instructor Guide
1995 Emergency Vehicle Operators Course (Ambulance) Participant Manual

EMS Technology Assessment Template
EMS Update: **NHTSA newsletter**

Federal Interagency Committee on EMS (FICEMS): Established by Congress in 2005 to ensure coordination among Federal agencies supporting local, regional, State, tribal, and territorial EMS and 911 systems. FICEMS was also created to improve the delivery of EMS throughout the nation.

Guide for Interfacility Patient Transfer
National EMS Advisory Council (NEMSAC)
New Guidelines for teaching **mass casualty incident triage support** unified emergency response
Provider and patient safety

RESEARCH

EMS **Research Agenda for the Future**
Evidence based guidelines for Prehospital care
Fatigue in EMS

Stop the bleed initiative
Transportation of children

WORKFORCE

EMS Workforce Agenda for the Future
https://www.ems.gov/pdf/workforce/Reports-and-Research-Studies/National_Workforce_Assessment.pdf
National EMS Workforce Data Definitions, 2013

Department of Health and Human Services

Office of the Assistant Secretary for Preparedness and Response
Agency for Healthcare Research & Quality (AHRQ)
Health Resources and Services Administration (HRSA)

- Emergency Medical Services for Children (EMSC)
- Office of Rural Health Policy (ORHP)

Rural Ambulance Crashes Literature Review (html, pdf)
Rural EMS Managers Awareness Program (html, pdf)
Quality Through Collaboration: The Future of Rural & Frontier Emergency Medical Services in the U.S. Health System (html, pdf)
Community-Based Needs Assessment: Assisting Communities in Building a Stronger EMS System (html, pdf)

- Distance Education in EMS: A Literature Review and Rural/Urban Comparison (html, pdf)
- Rural and Frontier EMS Town Hall Meeting Summary (html, pdf)
- Farm Rescue and EMS: A State by State Directory (htm, pdf)
- Rural and Frontier EMS Agenda for the Future: A Service Chief's Guide to Creating Community Support of Excellence in EMS (html, pdf)
- Rural Ambulance Service: Budget Model (html, pdf)

National Association of State EMS Officials (NASEMSO) – www.nasemso.org

Advocacy and Position Papers
EMS Compass: National EMS QI standards
EMS Instructor Qualifications (2010)
Fatigue in EMS report
Military to Civilian EMS Transition
EMS Workforce Planning and Development Guidelines
REPLICA – EMS Interstate Compact for license reciprocity in a disaster situation
2011 National EMS Assessment
National Model EMS Guidelines
Safe ambulances.org
Washington Update – subscribe for free
Road to Zero coalition: Achieving zero roadway deaths by 2050

National Association of EMS Educators (NAEMSE): www.naemse.org

EMS Educator Courses I and II (Part I required for Illinois Lead Instructor Status) – Site request form
Annual Symposium
Trading post – great resources for educational materials (members only section)
Advocacy, resources, publications, and position statements

National Association of EMS Physicians (NAEMSP): www.naemsp.org

Advocacy, resources, publications, position statements
Stop the Bleed toolkit for EMS Medical Directors
NAEMSP Position Paper - Defining Quality in EMS – 4/24/18
EMS Certification Review Courses and subspecialty Board Certification in EMS
EMS MD Base Station Course
Mass Gathering Care
The Medical Director Checklist

Centers for Disease Control and Prevention (CDC) www.cdc.gov

Blast Lung Injury: An Overview for Prehospital Care Providers
The Terrorism Injuries Information, Dissemination and Exchange Project
Model Communities Link EMS and Public Health
Field Triage Decision Scheme

Department of Homeland Security **www.dhs.gov**

Office of Health Affairs
Active shooter preparedness

Federal Communications Commission - https://www.fcc.gov/

General Services Administration www.gsa.gov

Federal Specifications for the Star of Life Ambulance https://www.ok.gov/health2/documents/KKK-A-1822F%20%2007.01.2007.pdf (STILL THE ILLINOIS STANDARD)

CAAS. Ground Vehicle Standard (GVS-2015), www.groundvehiclestandard.org

NASEMSO. Differences Between NFPA 1917 (8/29/12), KKK-F and ASTM, www.nasemso.org/Projects/AgencyAndVehicleLicensure/documents/NFPAfinalcondensedcomp arisons11-12.pdf. 4/5 NFPA. NFPA 1917: Standard for Automotive Ambulances, www.nfpa.org/codes-andstandards/document-information-pages?mode=code&code=1917.

Northwest Community EMS System

PEER EDUCATOR Approved DRAFT #2 3-2-16

In each location where NWC EMSS personnel and/or students are assigned for didactic or clinical instruction or supervised practice, there shall be instructional faculty designated to coordinate supervision and provide frequent assessments of the participant's progress in achieving System performance standards.

Qualifications: The faculty must be knowledgeable and competent in the content to be taught and effective in teaching their assigned subjects, and capable through academic preparation, training and experience to teach the courses or topics to which they are assigned (CoA).

Level	Credentials	Roles/Scope of teaching	Students authorized to teach	Approved curricular materials	Cost to agency
Peer I BLS Practical Skills Instructor	EMT or PM with unencumbered license and practice privileges in good standing in the NWC EMSS with minimum one year active field experience at EMS provider level being taught and off probation. Must be able to • Perform specific skills as designated within the level of EMS provider practice; • Teach specific skills as designated within the level of EMS provider practice. Must be recommended by their agency's Chief/EMS CEO or designee and be approved by the EMS MD or designee. Will receive Peer I privileges after demonstrating competency per System policy.	Demonstrate ability to assist with instruction and supervision of BLS practical skills. BLS skills within the NWC EMSS EMT scope of practice, National EMS Education standards, National EMS Scope of Practice Model, and Illinois EMS Rules.	EMTs • Provider EMTs • EMT class labs Paramedics • Provider EMTs & PMs • EMT & PM class BLS skill labs	National standard materials as approved by the EMS MD and System-specific skill sheets	Time at Peer I evaluation lab
Peer II ALS Practical Skills Instructor	PM with Peer I eligibility and expectations plus: • Approved preceptor or preceptor eligible Must be recommended by their agency's Chief/EMS CEO or designee and be approved by the EMS MD or designee. Will receive Peer II privileges after demonstrating competency per System policy.	Demonstrate ability to assist with instruction and supervision of practical skills. • BLS + ALS skills within the NWC EMSS EMT & PM scopes of practice, National EMS Education standards, National EMS Scope of Practice Model, and Illinois EMS Rules. This includes those aspects of CE classes where practice of known practical skills is included as part of the class content. This does not include CE classes where new skills are being introduced. • ALS skill mentoring	Same as Peer I for a PM plus: • PM class ALS skills or specific lectures/skills labs covering areas of special certification or credentialing (rescue, haz-mat etc.) • PM students during their field internship • TNS and ECRN labs for skills within scope of practice	Same as Peer I	Time at Peer II evaluation lab

Level	Credentials	Roles/Scope of teaching	Students authorized to teach	Approved curricular materials	Cost to agency
Peer III Adjunct faculty, subject matter expert, content matter expert	Peer II plus: • Minimum of 2 years of experience at EMS provider level being taught; or at least 2 years active experience in specific discipline/practice. • At least 2 years of documented teaching experience – Ex: ITLS, PHTLS, CPR, Pediatric Advance Life Support (PALS); fire service instructor 1 or higher; "LS" courses • Subject matter expert and/or certification in content if available. Must be knowledgeable in: • Performing and teaching skills of the EMS provider; • Course content in assigned subjects; • Effective methods for content delivery in a learning environment. Must be recommended by their agency's Chief/EMS CEO or designee and be approved by the EMS MD or designee. Will receive Peer III privileges after demonstrating competency per policy.	Demonstrates ability to: • Effectively deliver didactic content • Teach/demonstrate/evaluate psychomotor skills. Peer II plus: • CE prepared for internal presentation at the EMS agency at the EMD, BLS or ALS level to supplement, but not replace, the System CE program. • Review/reinforce pre and/or post course content or skills for System CE • Facilitate post-class reviews of credit questions or review of the post-test bank. • Prep candidates for System entry (cognitive & psychomotor objectives) • Present lecture content for entry – level EMT or paramedic courses	Peer II plus: • All EMS personnel for Agency-sponsored class offerings • EMT & PM class lecture presentations • May consider collaborative agreement with other EMS agencies	Peer II plus: Site coded curricula and teaching materials created by the EMS System or a Peer IV educator for specific topic(s) to be presented Standardized teaching content approved by national accrediting bodies for specific content (Example: EMDs; specialized rescue courses involving patient care)	Time to prepare for teaching; conduct classes; log attendance
Peer IV Primary instructor role with same knowledge and credentialing prerequisites and teaching privileges as an approved hospital-based EMS educators	Peer III plus: • Academic credentials from an accredited post-secondary educational institution commensurate with or above level being taught which usually requires a bachelor's degree in EMS or nursing. Approval of comparable equivalency to be determined by the EMS MD. • Academic preparation in educational methodology preferred. • Illinois Lead instructor license required before System designation as a Peer IV • Minimum of 4 years EMS experience • At least 2 years documented teaching experience.	Demonstrates ability to: • Write lesson plans; • Write learning objectives; • Effectively deliver didactic content; • Develop learning evaluation measures Responsible for: • Evaluation and remediation of student learning • Submitting agency-sponsored CE for IDPH site codes within IDPH and System guidelines. Peer III plus: • Teaching NWC EMSS created CE in lieu of hospital educator, including the introduction of new ALS skills. • May administer CE post-tests and practical exams (Ex. advanced airway mandatory assessment)	All EMS Personnel at their agency or identified through a collaborative agreement with other System agencies as approved by the EMS MD.	Peer III plus: Peer IV-generated curricular materials that must be created in compliance with NWC EMSS standards for CE development, approved by the EMS MD and submitted for IDPH for a site code at least 60 days before start of first class.	NAEMSE IC1 course; currently accepted Lead Instructor Course for IDPH Time to develop curricular materials; submit for site code; attendance at monthly System educator meetings; prep for teaching; conduct classes; complete class paperwork

Level	Credentials	Roles/Scope of teaching	Students authorized to teach	Approved curricular materials	Cost to agency
	• Documented successful EMS classroom teaching experience with lead instructor (Peer IV) potential in an entry level or continuing education program Must be knowledgeable in: • Course content; • Practical skills; • Effective teaching strategies specific to assigned topics; methods of student evaluation/counseling. Be capable of: • Teaching at the EMS provider level being taught; • Meeting the learning needs of the students; • Meeting the teaching needs of the content material • Developing/assessing/remediating student performance. Must be recommended by their agency's Chief/EMS CEO or designee and be approved by the EMS MD or designee. Will receive Peer IV privileges after demonstrating competency per System policy.				

All blue text is directly quoted from one of the following references:

DPH 77 ILLINOIS ADMINISTRATIVE CODE 515 SUBCHAPTER f; Section 515.700 Lead Instructor

Committee on Accreditation of EMS Programs (CoAEMSP) Interpretations of the CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the EMS Professions; Approved August 2015.

National Association of State EMS Directors (NASEMSO). (2010). EMS Instructor Qualifications: A Template to Assist States with Implementing the EMS Education Agenda for the Future: A Systems Approach. Accessed on line: www.nasemso.org

Charlotte Danielson's FRAMEWORK FOR TEACHING.

Charlotte Danielson's FRAMEWORK FOR TEACHING

DOMAIN 1: Planning and Preparation

1a Demonstrating Knowledge of Content and Pedagogy
- Content knowledge • Prerequisite relationships • Content pedagogy

1b Demonstrating Knowledge of Students
- Child development • Learning process • Special needs
- Student skills, knowledge, and proficiency • Interests and cultural heritage

1c Setting Instructional Outcomes
- Value, sequence, and alignment • Clarity • Balance
- Suitability for diverse learners

1d Demonstrating Knowledge of Resources
- For classroom • To extend content knowledge • For students

1e Designing Coherent Instruction
- Learning activities • Instructional materials and resources
- Instructional groups • Lesson and unit structure

1f Designing Student Assessments
- Congruence with outcomes • Criteria and standards
- Formative assessments • Use for planning

DOMAIN 2: The Classroom Environment

2a Creating an Environment of Respect and Rapport
- Teacher interaction with students
- Student interaction with students

2b Establishing a Culture for Learning
- Importance of content
- Expectations for learning and achievement • Student pride in work

2c Managing Classroom Procedures
- Instructional groups • Transitions • Materials and supplies
- Non-instructional duties
- Supervision of volunteers and paraprofessionals

2d Managing Student Behavior
- Expectations • Monitoring behavior
- Response to misbehavior

2e Organizing Physical Space
- Safety and accessibility
- Arrangement of furniture and resources

DOMAIN 4: Professional Responsibilities

4a Reflecting on Teaching
- Accuracy • Use in future teaching

4b Maintaining Accurate Records
- Student completion of assignments • Student progress in learning
- Non-instructional records

4c Communicating with Families
- About instructional program • About individual students
- Engagement of families in instructional program

4d Participating in a Professional Community
- Relationships with colleagues • Participation in school projects
- Involvement in culture of professional inquiry • Service to school

4e Growing and Developing Professionally
- Enhancement of content knowledge / pedagogical skill
- Receptivity to feedback from colleagues • Service to the profession

4f Showing Professionalism
- Integrity/ethical conduct • Service to students • Advocacy
- Decision-making • Compliance with school/district regulation

DOMAIN 3: Instruction

3a Communicating With Students
- Expectations for learning • Directions and procedures
- Explanations of content
- Use of oral and written language

3b Using Questioning and Discussion Techniques
- Quality of questions • Discussion techniques
- Student participation

3c Engaging Students in Learning
- Activities and assignments • Student groups
- Instructional materials and resources • Structure and pacing

3d Using Assessment in Instruction
- Assessment criteria • Monitoring of student learning
- Feedback to students
- Student self-assessment and monitoring

3e Demonstrating Flexibility and Responsiveness
- Lesson adjustment • Response to students
- Persistence

Teacher and Observer training by Danielson Group-endorsed consultants is recommended.

20140307