Comments submitted in response to DRAFT EMS Initial Education Program Designation policy

All comments are listed with the responses from OEMS. Thank you to all of those persons who provided comments on this policy – your feedback is important and will be considered when the policies are updated.

Completion Date/Time	Who Submitted the Comment
3/30/21 9:31:21	Shannon Weston, Dodge County EMS Director - Dodge County
3/30/21 11:33:56	Eron Sunshine - Lanier Technical College
3/30/21 15:10:37	Stacie Farmer - Douglas County Fire Department/EMS
4/3/21 11:06:55	Ryan Hollingsworth - Oglethorpe County EMS
4/5/21 15:28:05	James F. Jones - Toombs-Montgomery EMS
4/6/21 9:59:54	Kyle Atkins - Phoenix Education Group, Inc
4/8/21 20:16:18	Larry Causby - Cobb Fire and Emergency Services
4/8/21 22:53:00	Larry Causby - Cobb County Fire and Emergency Services
4/9/21 9:26:23	Barbara Kamplain - Georgia Institute of EMS
4/9/21 9:33:40	Thomas Kamplain - Georgia Institute of EMS
4/9/21 15:10:30	Megan Kamplain - Georgia Institute of EMS
4/13/21 15:23:09	Anthony Olson - LifeCare
4/14/21 13:15:34	Wayne Dunn - Rockmart Fire
4/15/21 1:27:38	Matthew Crews - georgiaemsacademy
4/15/21 12:01:45	Chris Youmans - United EMS
4/16/21 16:27:05	Stacie Farmer - Douglas County Fire Department
4/19/21 17:24:30	Kerry Markey-Cote - West Ga Tech College
4/29/21 13:07:07	Shawn Tatham - Wiregrass Georgia Technical College
4/30/21 0:44:50	Gwen M Peel - N/A
4/30/21 15:07:43	Richard Wheat - MetroAtlanta EMS Academy
4/30/21 17:54:21	Mitch Cobb - Laurens County EMS

Overall Notes:

- While not explicitly stated in the draft policy, this policy will have a timeline associated with full compliance of any requirements that remain (after updating it based on feedback received). It is not the intention to have this policy become fully effective and implemented without an appropriate preparation period.
- This policy addresses the needed items from DPH Rules 511-9-2-.16, and is consistent with the 2020 EMS Strategic Plan endorsed by EMSAC.

1.0 PURPOSE

1 comment:

Purpose should include a collaborative effort of the constituents that include EMS Agencies and Education institutions. There was no collaboration of workshop to ensure consensus.

Response – The public comment period with such a large group of agencies and institutions is part of the process that was used to help this document be collaborative. While consensus would be preferred, no law, rule or policy ever has consensus.

3.0 DEFINITIONS

No comments

5.1.1.1. Program sponsorship

3 comments:

#1 - Very reasonable requirement. Not clear on how the Department would determine how these resources are being met without copying CoAEMSP documentation. Having had a LOR by CoAEMSP for almost 5 years, I believe that their ideals and documentation place an unnecessary burden on the educational organizations. In short, the Department would be better served coming up with something else.

Response- The Department will use standard metrics for program sponsorship, such as those used by accrediting bodies like the CoAEMSP, NREMT, The National EMS Education Standards etc. This would include EMS agencies, Fire Departments, Educational programs (Department of Education) Hospitals, individuals with appropriate credentialing such as articles of incorporation etc. In the 2020 EMS Strategic Plan, Education Strategic Goal #1 (E) states “Model education program approval after the current accreditation standards”.

#2 - 5.1.1.1.1 need to define "adequate" resources. Perhaps refer to the minimal equipment list if that is what is being referred to here. 5.1.1.1.2- need to define "fiscally sound", this is arbitrary.

Response-The goal here is to support our program in getting the resources that they need from program administration. There will certainly be minimum standards such as the minimum equipment list to determine adequacy. Adequate is also subject to what is being taught at an individual location. IE: If an AEMT program has a cohort of 20 students the program director may feel it necessary to have multiples of items on the list. We would like to be able to support our programs in their request for additional equipment over the minimum equipment list. “Fiscally sound” means that the entity is able to conduct and fund the program, including payroll, utilities, supplies, equipment, etc., without danger of the students being kept from attaining the desired educational outcomes simply because of a lack of sufficient funding.

#3: Agreed – No Comment.

5.1.1.2. Program goals and outcomes

2 Comments:

#1 - Every program must have goals stated or otherwise. Valid requirement. Not clear on how the Department would determine how these goals and outcomes are being met without copying CoAEMSP documentation. Having had a LOR by CoAEMSP for almost 5 years, I believe that their ideals and documentation place an unnecessary burden on the educational organizations. In short, the Department would be better served coming up with something else.

Response- Goals are specific to each program, their community, and location, however, the Department will have template goals for programs to use. Thus, the program sponsor, program director, and advisory committee should determine the goals that may be specific to that individual program. Outcomes may be measured in attrition/retention rates, as well as NREMT pass rates. This is not designed to be a punitive process, rather a self-reflection for the program as to whether they are meeting stated goals. If not, then what steps can be taken to address that (possibly even changing the goal)

#2: Agreed – No Comment.

5.1.1.3. Program Director

6 Comments:

#1 - What are the qualifications to be a Program Director?

Response- An individual hired by the program to serve as the program director who can meet the responsibilities and duties of a program director, as outline in this policy.

#2 - Students are department employee and we don't get "screen student applications" prior to them being hired.

The screening is "if applicable", and having a hiring process at your agency qualifies for this. Programs may choose to use an entrance exam as a form of competitive admissions, but this is NOT required.

#3 - The policy needs to address a clinical coordinator and have the ability to officially delegate some of the clinical responsibilities to that person.

Response- Agreed, the policy needs to be expanded to include the role of each position within an education program. The program director does have the ability to designate any duties to a qualified instructor.

#4 - Please clarify this section because it almost reads like you are recommending that Tech colleges have 1 program director for EMTB/AEMT and another for Paramedic. Which when we bring this up to our administration they are not happy about. What is TCSG's input on this and if this is what you want have you spoken with them about whether or not they are going to recommend this to college administration.

#5:
Response-The OEMS only requires that a program have one (1) program director. There are several programs that do have a Paramedic program director and an EMT/AEMT program director, but this is NOT required. This was the reason that we added the position of "program admin" to the LMS so as to allow those persons the same permission levels as the program director. The OEMS allows each program to determine the appropriate structure of administration – OEMS just requires that there be at least one named Program Director.

> 5.1.1.3.1- need to define "adequate amount of time", this is arbitrary.
> Response- No two programs are the same. The OEMS will not try to manage a program by specifying a set amount of time. This is up to the program administration for any individual program to determine what is adequate, and if the program director feels

that they do not have adequate time to address the program director responsibilities, this statement of “adequate time” allows for the program director to approach their sponsor to request that more time be allotted for program director responsibilities.

5.1.1.3.1.1 there only shows EMT and AEMT programs and no paramedic programs.

Response- This could be updated to include Paramedic. It was not included because CoAEMSP already has requirements in place for program directors of Paramedic programs.

5.1.1.3.1.1.1- need to define "adequate progress toward completion of the program;" this is arbitrary

Response- No two courses are the same. The OEMS will not try to manage a course by specifying what adequate process is. This is up to the program administration for any individual program to determine what is adequate.

5.1.1.3.1.1.2- "review and supervise the quality of instruction provided by the program;" is undefined. Perhaps state "ensure that the quality of instruction meets the objectives of the program"

Response- This proposed change will be considered along with the other comments.

5.1.1.3.2- seems repetitive of 5.1.1.3.1

5.1.1.3.2.4- should not only be program directors to submit notifications and approvals, Lead Instructors should be able as well.

Response- The OEMS holds the program director as the person responsible for the administration of a program. If the program director chooses to make a lead instructor a program admin and give them the permissions of the program director that is up to the program administration.

5.1.1.3.2.6- this is handled by the institutions advising and registration and confirmed with the PD. Should not be in a state rule.

Response- Very few EMS education program have advising and registration departments. In most cases this is the responsibility of the program director – if this is handled by the sponsor’s administration department, then the PD has ensured that it is done.

5.1.1.3.2.15- Medical Director does not evaluate instructors, this should not be a requirement.

Response- Medical directors often do and should evaluate the effectiveness of any individual instructor based. This is the same concept of an agency medical director supervising a medic in the field through QA.

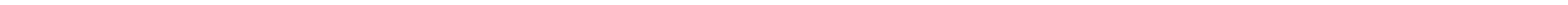
5.1.1.3.2.16- Medical Director does not evaluate internship programs and clinical sites, this should not be a requirement.

Response- Medical directors do evaluate the effectiveness of internship programs and clinical sites. They may not physically go to a site for an “inspection” but review of pass rates, file reviews, and Terminal Competencies the Medical Director is evaluating the effectiveness of field and clinical sites.

Creating rules like these will drive away Medical Directors from the programs and the programs will lose accreditation and ability to function. It is hard enough to have them more involved with the payment they receive.

Response- In regard to accreditation- this is referring to CoAEMSP accredited Paramedic program where the medical director already has these responsibilities. Therefore, for Paramedic programs there is no additional burden being placed. For EMT/AEMT programs this is intended to provide direction on what the medical director should be doing beyond signing an application.

#6: No comment, fine as written.



5.1.1.4. Advisory Committee

9 Comments:

#1 - 5.1.1.4.1 - I agree that an Advisory Committee is needed for the Paramedic and AEMT programs. These programs are usually long standing and occur with some frequency. However, EMT classes, while some ar long standing, others only occur if Grant funding is available. I'm not convinced that an Advisory Committee would be of much use to these programs. Most of the grant classes are very low budget with typically only one instructor.

5.1.1.4.11 - This item could severely delay the start of a course to the point of losing their grant funding.

5.1.1.4.12 - Minimum requirements:

Current Student - Will not be known until the course starts, therefore cannot be met prior to program designation)

Graduate - Impossible if no previous courses

Program Sponsor, Faculty, Employer - Could all be the same person in a rural EMS course.

Response- It is prudent that any education program responsible for preparing individuals for a career of providing healthcare have at a minimum taken the time to perform an analysis of the community, its needs, the goals of the program, and the ability of the program to meet those needs/goals. This section can be re-worded to indicate that if the program does not have any graduates (or their employers) or current students that the advisory committee would not have those positions. It is also our experience that even grant funded courses have an advisory group – while not normally called this, they have a group of people that are advising on the creation of the program. The positions needed for a new EMT program include 5 people (may be less based on dual roles faculty/sponsor), all of which is already included in the creation of a program (with the possible exception of a member of the public).

A new EMT program would only need to have the following:

- Program Faculty (which may also be the Program Director)
- Program Sponsor (may be the EMS Agency Director)
- OEMS Regional Training Coordinator
- Program Medical Director
- A member of the public

The revised policy (based on comments) will be modified to make clearer the members that must be present for a new program.

#2 - While the idea of an advisory committee is good, some clarification is needed on graduates, since new programs will not be able to have graduates. The idea that an EMT/AEMT program have a Key Government Official is noble, but advisory committees should be at

the discretion of the host institution. That being said, the recommendation could be made to have the Regional Training Coordinator as a part of the committee, but mandating is something that I do not believe is in the spirit of creating an advisory committee. We don't tell people who to have on a board of directors, so we should use the same approach with this. Suggest for sure, but not mandate since that is at the decision of the institution.

I believe that an advisory committee at the EMT/AEMT level is needed, but it should be more flexible especially for newer programs since it can be extremely difficult to find someone to fill each role. I know its modeled after the CoEMSP standards, but the OEMS/T is not an accrediting agency.

Response- Please see response to comment #1 above. As a regulatory agency, the OEMS is the agency that does designate EMS Initial Education programs pursuant to DPH Rule 511-9-2-.16.

#3 - Students are county employees being trained for internal employment. This means that the advisory committee will be primary comprise of CCFES personnel. The graduates, faculty, sponsor, medical director, and employer are CCFES.

Response- This would be allowed under the draft policy.

#4 - The advisory committee should be there to advise not to approve programs and or operational procedures. The requirement of having the advisory committee approval procedures will cause a delay in some operational aspects of the program and will establish a new layer of "red tape" that will cause consequences for the program and students.

Response- Advising is the purpose of an advisory committee. There is no requirement that the advisory committee approve individual procedures, and the advisory committee does not “approve” the program – that is the role of OEMS. The advisory committee is to assist the program director in ensuring that the needs/goals of the program and students are being met. Advisory committees that are properly structured can be a great asset to programs.

#5 - This is the first thing that I see as unreasonable. I understand that colleges may have an advisory committee, but not private EMT schools that only have 5-10 employees. Private small businesses are not being thought about at all in this. It seems as if every school should be a large college that is structured the same way. The reason why we have students is that our students are not able to learn in a typical college setting. This may be from lack of time or lack of personal funds. Public businesses and institutions have advisory committees, not small private businesses. In each meeting, it continues to be noted that there is a lack of EMTs. If there is a lack, then stop putting further restrictions on private EMT schools. If you need more EMTs, then let us train more EMTs.

Response- Georgia is fortunate to have the number of private or otherwise non-collegiate programs that deliver a large amount of students to the workforce. Many EMT programs already have advisory committees in place and are successful with those. It has also been noted that programs with advisory committees tend to have better long-term success. It is our hope to continue to grow the EMS

education opportunities for students across the state by putting in place items, such as advisory committees that support those goals. The advisory committee is to assist the program director in ensuring that the needs/goals of the program and students are being met. Advisory committees that are properly structured can be a great asset to programs.

#6 - Advisory committees are largely unnecessary and unhelpful. Not clear on how the Department would determine how these goals and outcomes are being met without copying CoAEMSP documentation. Having had a LOR by CoAEMSP for almost 5 years, I believe that their ideals and documentation place an unnecessary burden on the educational organizations. In short, the Department would be better served omitting this requirement.

Response- It has been the experience of the OEMS that advisory committees contribute to the long-term success of programs and students. It is our hope to continue to grow the EMS education opportunities for students across the state by putting in place items, such as advisory committees that support those goals. The advisory committee is to assist the program director in ensuring that the needs/goals of the program and students are being met. Advisory committees that are properly structured can be a great asset to programs.

#7 - Do we need a separate advisory committee for EMTB/AEMT then we have for Paramedic. It is hard enough to get advisory members to come to 2 meetings a year let along have more than that. Can the public representative be someone who has a previous EMS background but is not currently working in EMS or does it need to be someone with no EMS background.

Response- There does not need to be two separate committees unless the program wants that. There is only a requirement for an annual meeting. While someone without an EMS background would be preferred it is not a requirement

#8 - 5.1.1.4.2- need to define "significant representation", perhaps state "ensure a quorum"
Response- Please refer to the chart to determine representation.
5.1.1.4- The whole policy should read " must maintain compliance with the most current CoAEMSP standards and policy.
Response- CoAEMSP requirements do not apply to EMT/AEMT programs, and this program addresses all levels of EMS initial education.
5.1.1.4.4- this is a CoA requirement already, why the redundancy?
Response- CoAEMSP requirements do not apply to EMT/AEMT programs. Therefore, these requirements are in place for those programs.
5.1.1.4.12- Representation is too restrictive and requires too much as required. Mandatory Graduate representative is not always achievable as many will not participate since they have no personal interest and are not being paid, this should be optional/preferred. Need to define Program Sponsor Representative", the instructors and directors are already present and can represent in this role, if not, having another sponsor representative is not possible with institutions that have multiple programs. "Representative of the public" is not possible, this should be optional/preferred. If there are requirements for many of the positions to meet the requirements for the AC

meeting, you will find many will not have meetings due to this. This is an example of why a collaborative workshop should have been conducted.

Response- Program sponsor is anyone in the administration above the level of a program director (except in cases where the program sponsor may also be the owner and the program director).

#9 - Non program affiliated committee Chair would not be as knowledgeable of needs.

Response- Advisory committees explore the needs of the program, and the chair (who's primary role is to run the meetings) will be educated by that process.

5.1.1.5. Medical direction

8 Comments:

#1 - Agree - However, training should be provided via TRAIN for new Medical Directors

Response- The OEMS is working with EMSDAC to create a course to be placed on TRAIN.

#2 - Most medical directors do not have any prior knowledge of EMS programs since this is pretty much a nitch market. I would suggest that the language in 5.1.1.5.1 say that the Medical director should be knowledgeable about EMS systems and other educational programs, but not specifically EMS Education programs

Response- Great point. This will be considered in the policy revision based on these comments.

#3 - 5.1.1.5.1.4. review the progress of each student throughout the program, and assist in the determination of appropriate corrective measures, when necessary.
5.1.1.5.1.5. Corrective measures should occur in the cases of adverse outcomes, failing academic performance, and disciplinary action.
5.1.1.5.1.6. ensure the competence of each graduate of the program in the cognitive, psychomotor, and affective domains;

- These roles as above mentioned is the the job of the Program Director. The physician who is the Medical Director should oversee the progress of the EMS PROGRAM and work with the Program Director in case corrective measures are needed for the quality of the program. Reviewing each student by the medical director is not a realistic approach and very costly for a small EMS school program who is a private business.

I have worked in a tech school before Here in Georgia in a healthcare professional program and I have not seen a medical director/physician in a state school of Georgia present in a daily basis being around these programs and involved actively in its educational activities and working with the Program Director.

The cost of paying the services of the medical director by state owned EMS schools versus private schools who are much smaller in comparative is a big issue in this area and conflict financially and academically. The EMS school department owned by the state does not worry about the financial capacity to pay such physicians. Small EMS schools whose revenue is much smaller compare to state schools have to sustain and pay such physician services especially if the frequency and increase physician presence is required in campus and online education.

Also, most of these medical directors who are also physicians own their own practice or work for another hospital and institution so the time frame of reviewing each student' progress is not realistic at all.

Response- These responsibilities should fall to both the PD and the MD. As noted, the MD may simply be reviewing files/forms that the PD has gathered. It is prudent that the MD be involved in the program to ensure effectiveness. Agreed, it is impractical to assume that an MD would work daily. There is no requirement to have a medical director that is full time or daily. All programs, regardless of their affiliation (private vs. non-private) are able to benefit from physician oversight. Keep in mind that ALL EMS agencies must have medical direction, as EMS is not independent practice, and having physician clinical oversight is paramount to the success of the clinical education that occurs in EMS initial education programs.

#4 - The Medical Director should be involved with programs but this is too much! This is going to basically require a Full-Time Medical Director and they are extremely expensive. As of right now, most programs are on a very tight budget and what you are asking in this policy is that we will have to come up with a drastic increase in hours. I do not see where this level of involvement would drastically benefit students. Students need access to Experienced Field Providers who know exactly how to do the job.

Your proposal here will result in one of three things:

1- Increased program cost
2 - Decreased program instructors to offset the increased cost of Medical Direction
3- A decrease in programs offered.

Additionally, the Medical Director should not be supervising or running the program. That is the job of the Program Director and Instructional personnel. The Medical Director should be used as a Subject Matter Expert who can advise personnel on the safe and appropriate administration of medical procedures and treatments. The Medical Director should be involved with programs but this is too much!

Response- There is no requirement for a full-time medical director. Medical directors do not supervise or “run” the program. This policy addresses the responsibilities of a medical director – this is the first time these have been specified in Georgia in a policy, but all programs have always been required to have a medical director. This policy helps to ensure that those physicians are not just present in name only but are actively involved in the clinical oversight of the program.

#5 - Why would someone that does not actively work in EMS or even go through any type of EMS training determine the type of classes needed to train EMTs? I understand having a part in the education, but not signing off on everything. Also, this is ANOTHER added cost that would be thrown on to private EMT schools. This sounds like a way to get rid of small businesses. It also sounds like another way to limit EMT schooling. Aren't we currently facing a lack of EMTs? If that is true, then why are there more and more regulations being thrown into schools?

Response- Physicians have a broad skill set that includes care of patients regardless of the setting in which they are in. It is prudent that EMS education programs have physician oversight of the clinical aspects of a program. This requirement has also always been a requirement. Keep in mind that ALL EMS agencies must have medical direction, as EMS is not independent practice, and having physician clinical oversight is paramount to the success of the clinical education that occurs in EMS initial education programs. Having an active medical director that has oversight of the clinical aspects of the program will actually help the program achieve better success which would lead to an INCREASE of the number of available EMS graduates.

#6 - This is another CoAEMSP requirement that should not be copied. Employing a licensed Medical Doctor to participate in the administrative, teaching, or other is a waste of resources and adds very little to the program. The role of the Medical Director should be defined. I would suggest providing Medical Oversight for the program (ensuring that what is being taught is effective). In my years of teaching, there is still no 'canon'. Example, go to the field and find a Paramedic who knows the sequence of events that one would take to hold c spine, open an airway, and ventilate (sounds simple enough, but the what you will find is a shocking lack of understanding of the very basics of EMS thought). If only there were people who could be expected to know and teach these things (it won't be a Medical Doctor). The Medical Director should work in conjunction Program Director or Lead Instructor to develop the course with efficacy in mind. Efficacy being framed with the DOT Instructional Guidelines, ECC Guidelines, and current practice. In terms of student reviews, I would suggest the 'SUM' model I developed for my Paramedic program where the Medical Director was there to witness students in scenario exams.

Response- This policy does define the requirements of the Medical Director. As noted in the policy the role of the MD is to work in conjunction with the program director to achieve the goals of the program. See responses to the comments above.

#7 - 5.1.1.5.1- approval of the department should not be required f they are already approved by the National accrediting body. The entire policy is redundant to CoAEMSP guidelines and requirements. The policy should reflect "ensure the program is complaint with the current National accrediting guidelines and policies"
5.1.1.6.3- The word practice needs to be removed. Students practice outside of the classroom without supervision. Once the skills has been taught and evaluated by the instructor, practice should be at the discretion of the instructor/coordinator/program. Many programs do not have the resources to accommodate supervised practice sessions outside of the normal class time.

Response- The Georgia OEMS is responsible for approving courses that are taught by accredited programs, and the national accrediting body (CoAEMSP) still requires that a program be approved by the state EMS regulatory authority.

#8 - #5 and 9 put tremendous pressure on Medical Directors. The Program Directors have been empowered to manage students based on program guidelines.

Response- The medical director should be involved with the program director to make corrective measures for students. The terminal competency and file reviews are ways that a medical director could verify competence.

5.1.1.6. Instructional personnel

6 Comments:

#1 - 5.1.1.6.1 - Does the state have a sufficient amount of EMT Instructor/Coordinators to meet this item.

Response- Yes, this is not a new requirement that there be a licensed instructor present.

#2 - In 5.1.1.6.1, it states that an EMS Instructor/Coordinator must be present at all didactic and lab instruction. This can be extremely difficult to have physical presence and it also brings into question how to do distance education if the host campus is in one place and a satellite campus is in another with just an EMS instructor. It would make more sense to put the burden on the institution to ensure that there is proper training for the instructors, including adjuncts, to ensure that standards are met, but if the requirement is just 1 I/C per course and that person must be present each minute of all instruction, that doesn't seem practical. If we are going to allow the use of Adjunct instructors, those people should be able to operate under the guidance of the I/C without the I/C being physically at each class or lab session

Response- This section needs to be re-evaluated as it is possible for a SME or other to be a lab instructor. Moreover, there should be a licensed EMS I/C present on the premises that may not be involved in the direct teaching at that time.

#3 - Very good. I firmly believe in the 1:6 student ratio.

#4 - Change 1:6 ratio to: based upon the isolated skill, "an adequate student to instructor ratio" must be maintained. This allows for greater flexibility and more realistic expectations. We will adapt our classroom format if we don't have enough adjuncts. Experienced instructors don't need a 1:6 ratio in AHA either.

Response- There are multiple documents, including the NIMS that indicate the span of control to be at, or around this ratio.

#5 - 5.1.1.6.4- unpaid instructors, such as SMEs that are not in EMS should not have to be logged into LMS. These guest instructors are providing a free service to enhance learning and may not want to provide their specific details required in LMS.

Response- There is no requirement to have SME listed on the LMS. The policy address those that are involved in the supervision/evaluation of students. It is assumed that a SME is a quest lecturer, otherwise they have another position and would be listed in the LMS.

#6 - #3 This would be financially impossible for medium and small EMS services working with grant classes to maintain 1 instructor to 6 students in every classroom since most are now blended or flipped. Most services are using Training Coordinators in dual roll and depending on volunteers from their service to fill in gaps for labs.

Response- The 1:6 ratio is not a new requirement. This has been in place for years and is reflected on the minimum equipment list. This policy, nor the minimum equipment list require that there be a 1:6 ratio except for skills and only while skills are being taught. If an instructor has 12 students, they would split the group into 2 groups – this policy allows for flexibility in the blending/flipping of classrooms. In the revised policy, this will be made clearer.

5.1.1.7. Adequate Financial resources

8 Comments:

#1 - A ratio of 1 instructor for each 6 students must be maintained during skills instruction, practice, or evaluation.
This is nearly impossible to keep and maintain this ratio. This would require either a massive increase in full-time and adjunct or reduction in class size to less then 10 per class. At which point I cant not even hold a class with that little number of students. Once a group of student is taught how to do a task such as CPR and checked off by the instructors they no longer need to be babysat on this skill. A 1 to 10 ratio would work better for our program with produces both a high number of graduates and students that are prepared once they graduate our program.

Response- The 1:6 ratio is not a new requirement. This has been in place for years and is reflected on the minimum equipment list. This policy, nor the minimum equipment list require that there be a 1:6 ratio except for skills. If an instructor has 12 students, they would split the group into 2 groups. There is also not a requirement that students should be "babysat" after they have been taught a skill.

#2 - 5.1.1.7 - How will this be documented?

Response- The ability to meet all the requirements of this policy and meeting the minimum standards outlined here.

#3 - Extremely vague. This does not at all speak to what is meant by "adequate" financial resources. Does this mean that the school/agency/etc should have 6 months of cash on hand or does it mean that they have been in business for a while? Also, what is the measurement for this standard? While I believe that schools should be able to show that they can financially support a program, there must be some form of measurement. Maybe this should be a budget that is present, but even then, financials are something that many organizations may not be willing to disclose since that is confidential information. It might be helpful to create a worksheet for schools to fill out that give a score that shows their financial stability.

Response- The ability to meet all the requirements of this policy and meeting the minimum standards outlined here. "Adequate Financial Resources" means that the entity is able to conduct and fund the program, including payroll, utilities, supplies, equipment, etc., without danger of the students being kept from attaining the desired educational outcomes simply because of a lack of sufficient funding.

#4 - Programs should have to provide adequate insurance coverage. That would be workers comp and liability insurance. Insurance should be sufficient to protect students and staff.

Response- Great point.

#5 - This sounds as if you would increase the cost to run a program at a small private school, offer zero support, cause us to increase tuition prices which will lead to fewer students enrolling, and then the school closing down. Again, this is just a way for fewer people to go to EMT school (and aren't we in need of more EMTs). These policies suggest otherwise.

Response- Nothing in this policy is designed to increase the monetary cost of a program. This policy is designed to help programs be more successful in their student completion rates and student pass rates. No two programs are the same. What is sufficient for one operation may be wholly inadequate for another. The decision of adequate should be made by the program administration in conjunction with the advisory committee. Part of the reason for this section of the policy is to protect the students, so that programs can't say that they did not adequately prepare the students to enter the workforce because of "lack of funding".

#6 - Don't disagree. There is precedence for such a requirement. How will that be assessed? Will programs that do not fall under DTAE have to provide financial statements or tax returns to comply with this requirement?

Response- The ability to meet all the requirements of this policy and meeting the minimum standards outlined here. Part of the reason for this section of the policy is to protect the students, so that programs can't say that they did not adequately prepare the students to enter the workforce because of "lack of funding".

#7 - Maybe a bit more clarity on this. One persons idea of adequate financial resources and anothers is totally different.

Response- "Adequate Financial Resources" means that the entity is able to conduct and fund the program, including payroll, utilities, supplies, equipment, etc., without danger of the students being kept from attaining the desired educational outcomes simply because of a lack of sufficient funding.

#8 - 5.1.1.7- need define "Adequate Financial Resources" Also, resources should be capitalized as with all subject headings.

Response- "Adequate Financial Resources" means that the entity is able to conduct and fund the program, including payroll, utilities, supplies, equipment, etc., without danger of the students being kept from attaining the desired educational outcomes simply because of a lack of sufficient funding.

5.1.1.8. Adequate physical resources

6 Comments:

#1 - Can the Minimum Equipment Required for Initial EMS Education list be updated? Currently, the only one that programs have access to was last updated in early 2010 and requires equipment at the EMT/AEMT level that is no longer used or allowed under the scope of practice. If this is to be the standard, we need to ensure that we update this to the current guidelines.

Response- The minimum equipment list was updated in April and is available on the OEMS website.

#2 - Instructional programs should not be required to have medical equipment that is not required to be on an ambulance.

Response- The national education standards requires the teaching of skills that may or may not be pertinent to medics in Georgia. Educational programs are teaching a national curriculum.

#3 - This is understandable. Schools need to have all equipment necessary. What I don't quite understand though is why each school needed a LUCAS device when services are not even required to have them. This seems like training that could be done once someone gets hired.

Response- The national education standards requires the teaching of skills that may or may not be pertinent to medics in Georgia. Educational programs are teaching a national curriculum. Programs are not required to have a mechanical CPR device, they can either have one, or have an agreement to use.

#4 - Remove the requirement for a checkout log and document use of that equipment. (Example: we loaned each high school with EMT programs equipment to use for the duration of their program. The expectation they document each time they use that equipment is not realistic).

Response- Great point.

#5 - 5.1.1.8- Same, define adequate physical resources and subject heading should be capitalized
5.1.1.8.1- need to define sufficient.

Response- No two programs are the same. What is sufficient for one, may be wholly insufficient for another.

#6: Agreed – No Comment.

5.1.1.9. Adequate clinical and field internship experience/resources

7 Comments:

#1 - 5.1.1.9.6 - 1 EMT Team Lead is required. The Terminal Competency Form state Teams Leads are required for AEMT Level only.
5.1.1.9.6.2 - What qualifies as a Team Lead for the EMT? -
Need a definition for "Termination of Care in the Field".
5.1.1.9.6.3.1 - If the EMT and AEMT require 1 and 5 Team Leads respectively, then neither could count Pt Refusals based on this no more than 10% requirement. Paramedics may count 2 of 20 Team Leads that resulted in a Pt Refusal. To simplify, I suggest that NO PATIENT REFUSALS MAY BE COUNTED AS A TEAM LEAD.

Response- The TC have been updated. We will clarify what is a team lead. We will consider that and determine what impact not allowing refusals might have on our programs.

#2 - There should be some provision for patient contacts like pediatrics since these are extremely hard to come by, especially since many programs are unable to get into facilities that have pediatrics - CHOA for instance will not allow any clinical EMS students into their facilities without an extensive process and even then, they only allow for this to be for Paramedic students

Response- There are multiple ways to get pediatric contacts for EMS initial education students – this could be asking those faculty/staff/students who have children to come in and allow for healthy assessments of kids. Another way to do this would be to get clinical contracts with pediatrician offices. This is one of the things that the Advisory Committee can help with – to provide ideas and contacts for this to happen.

#3 - There is a need for clinical and field hours. I do notice that there is a change in team lead requirements if I am not mistaken. I for the most part agree with this, but 5 may be too many team leads to requiring for an AEMT student especially if they came straight from EMT school. Why is this being changed? Are jobs just not doing onboarding training anymore?

Response- The requirement for 5 team leads as an AEMT is not a new requirement. It is important for AEMT students to attempt as many team leads as possible – this helps them be more prepared to enter the workforce.

#4 - In my opinion a prerequisite for acceptance into the paramedic program should require at least one year (preferably 2 years) of “in the field time” on the truck as an EMT or first responder. Be it a fire rescue truck or an ambulance. I understand the urgent need for medics but turning out medics that go from basic EMT straight into medic school without having any field experience is detrimental to the service and patients.
Response- Programs have the flexibility to determine what entry requirements they will have for their programs. The OEMS does not have a prerequisite on the amount of time someone has been licensed to enter a program.

#5 - Team leads should be assessed at the school by the instructional staff. Vocations that are union based use a similar method (journeyman have no defined time period to get to the next level) to the team lead. EMS programs in Georgia are cohorted and approved by the Department and often taught at colleges. I'm not sure that even nursing programs use such a model with their thousands of hours of clinical training. No real training program would allow non instructional personnel who are probably only minimally competent. If Georgia had a better trained EMS, this notion of allowing the current workforce to train next workforce might make more sense. Further, to burden an uncompensated EMT/AEMT/Paramedic with additional responsibility and additional paperwork seems cruel when much of our EMS workforce works in excess of 72 hours a week.

Response- The only way to observe a student's ability to manage a call is to be present when that call is completed. The OEMS feels like Georgia has a highly trained and very competent workforce that can and does train its future workforce.

#6 - For interacility transfers to be counted as a team lead what needs to happen? Are there only certain ones that will be accepted and if so can we clarify that.

Response- The student must be the one in charge of the call, that makes the patient care decisions and generally "runs" the call with no supervision needed.

#7 - 5.1.1.9- define adequate. The term adequate is nebulous and needs further definition. Adequate for and urban vs rural area, high vs low volume differ.

5.1.1.9.1- need to define adequate

5.1.1.9.6- this rule is redundant to programs that complete electronic reporting in their tracking system (Fisdap, Platinum).

5.1.1.9.6.1- The following points should be bullet pointed, not numbered as rules. These also should not be in a rule as they are learning objectives, not rules.

5.1.1.9.6.2- define termination, termination of the patient or care?

Response- No two programs are the same. What is adequate for one may be wholly inadequate for another. This should be determined by the program administration and the advisory committee. The policy says "termination of care"

5.1.1.10. Preceptor Training

10 Comments:

#1 - I didnt see where a preceptor has to have a certain number of years at the level they are precepting.
ex: Be a paramedic 2 years to precept a paramedic student.
Would it be better to have a uniformed preceptor training program across the state. If I went to work at serivce B and was a preceptor at service A the training would be the same.

Response- There is not a requirement for how long someone has to be to be a preceptor. The OEMS is developing a preceptor program.

#2 - The preceptor training must be approved by the Department, and the Program must maintain a roster of all persons who complete the preceptor training.
We do send out preceptor training and do keep a list of preceptors in regards to the students leadership and capstone clinical. It would be unrealistic to keep a record or list of that is even remotely up to date. We currently use platinum planner as our record keeping for preceptor training and list. The current turn over of paramedics and AEMT in our area makes it almost impossible to know who has had the training and keep an adequate list of preceptors. Also, what about students that are assigned nurses are preceptors in the ER? Would they all so be required to attend preceptor training?

Response- If a program is already maintaining a list of preceptors then that is all that is required. Further clarification will be provided for in-hospital settings which would be that someone in the facility be familiar with precepting students (this could be a charge nurse).

#3 - Please provide a State Sponsored Preceptor course on Train that meets this policies objectives.

Response- The OEMS is developing a preceptor course that will be placed on TRAIN.

#4 - Agreed - However, What are the qualifications for each level of Preceptor?

Response- Currently that they be listed as a preceptor for that program, most programs have certain requirements and provide education.
#5 - Since many programs use large services, there should be clarification on how to properly train and maintain a list of preceptors - since the school nor the student usually have any control over who the student rides with.

Response- Clarification will be given.

#6 - Preceptor Training should be a requirement for ALL EMS personnel in the state. We need to make clinical education more accessible and not restrictive. Many sites provide this for free and we should not make it more difficult or costly. Currently, the state requires 8 hours of Peds, 4 hours of Trauma, and 4 hours of Cardiac. Just add another 4 hour category of Preceptor and then we can all assure that students are able to complete their rotations with an approved preceptor.

Response- Requiring that all medics obtain mandatory preceptor training is not prudent.

#7 - Have one preceptor class that the Department runs on their OEMS learning management system. The overworked and competent EMT/AEMT/Paramedic that a Program Director would choose does not need to be punished by having to sit through 18 different preceptor programs.

Response- The OEMS is developing a preceptor course.

#8 - Please offer preceptor training on TRAIN! Huge need

Response- The OEMS is developing a preceptor course.

#9 - Is there any thought about coming up with a state approved preceptor training course and mandating that all preceptors go through it. With many clinical sites taking in multiple programs students to ride, it is difficult to get preceptors to complete more than 1 course it would be easier if we had master course and then everyone could just give specifics of there program.

Response- The OEMS is developing a preceptor course.

#10 - 5.1.1.10.1- define adequate

5.1.1.10.2.1- the following criteria should be bullet pointed, not separate rule numbers.

5.1.1.10.4- requiring the Department to approve preceptor training to arduous and should be removed. If you are stating adequate, then the program should determine the adequacy based on the criteria listed. If the Department is approving preceptors, then the department should provide the basic training based on their criteria listed and approve them. Additional, localized training should follow by the institution.

Response- The OEMS is developing a preceptor course.

5.1.1.11. Academic and administrative policies, evaluations, procedures and records retention requirements:

7 Comments:

#1 - 5.1.1.11.11.1 - This item states that the Medical must sign the Terminal Competency Form. The form indicates by * that the Medical Director signature is "recommended".

Response- This will be reviewed.

#2 - For didactic/cognative documentation - exams should not be the only standard allowed for this (not only because they are vastly ineffective, but they also aren't supported by all current research)

Response- "Exams" can take many forms, but programs should prepare students for the rigors of the cognitive NREMT exam.

#3 - Why does the program direct complete the terminal competency form? This is something that the instructor should be doing. The instructor is the person that is keeping up with the student's progress and knows where the student stands. Why is more and more work placing out of the lead instructor's lap and on to the program director? The program director can not do an effective job if all they ever do is paperwork that can be completed by other people. Also, why is this something the medical director needs to sign? What doctor has time to just sit at a school all day and do paperwork when they should be at their hospital? This is again going to limit the number of schools open WHEN THERE IS A SHORTAGE OF EMTs.

Response- The program director is responsible for all aspects of the program and therefore should sign off on the terminal competency form – the policy does not say that they have to be the one to fill out the document. For a physician that has agreed to be your medical director, they are agreeing to oversee the clinical aspects of your program – signing off on the students' terminal competency forms is a way to ensure medical director involvement. This does not limit the number of schools, but is ensuring that all students are protected and that educational outcomes are ensured.

#4 - Anybody who has ever been a Program Director for a CoAEMSP can attest to the unbelievable amount of paperwork generated for each student. This administrative burden placed on our Paramedic programs has already crippled and neutered countless Program Directors creating a nationwide revolving door. Little or no benefit would be derived from these documentation requirements.

Response- Documenting the progress and terminal competence of students is a necessary component of clinical educational programs. This is no different than requiring EMS personnel to document the progress and care of their patients. Documenting what we do and how we do it is part of the healthcare industry. Nursing programs have FAR more documentation requirements than are required here.

#5 - Take out requirement for medical director to sign the terminal competency forms.

Response- For a physician that has agreed to be your medical director, they are agreeing to oversee the clinical aspects of your program – signing off on the students' terminal competency forms is a way to ensure medical director involvement.

#6 - For records retention, does it need to be hard copies or can the records be digital? As well for exams do we need hard copies or can it be kept in our LMS or other digital format.

Response- Digital is acceptable.

#7 - 5.1.1.11.5- should read "minimum of two years or according to the National Accreditation body or Sponsoring Institution, whichever is greater"

5.1.1.11.9- the following criteria should be bullet pointed, not separate rule numbers.

Response- This is the formatting of DPH policies.

5.1.1.12. Student Portfolio

5 Comments:

#1 - 5.1.1.12.2.1 - This item states that the Medical must sign the Terminal Competency Form. The form indicates by * that the Medical Director signature is "recommended".

Response- This will be reviewed.

#2 – Why is the medical director signing everything? What good does that actually do? Is this just a test to see if anything will improve, or are these just added costs to programs to just see what happens? Is there any backing to how this can actually improve anything?

Response- For a physician that has agreed to be your medical director, they are agreeing to oversee the clinical aspects of your program – signing off on the students' terminal competency forms is a way to ensure medical director involvement.

#3 - Anybody who has ever been a Program Director for a CoAEMSP can attest to the unbelievable amount of paperwork generated for each student. This administrative burden placed on our Paramedic programs has already crippled and neutered countless Program Directors creating a nationwide revolving door. Little or no benefit would be derived from these documentation requirements.

Response- Documenting the progress and terminal competence of students is a necessary component of clinical educational programs. This is no different than requiring EMS personnel to document the progress and care of their patients. Documenting what we do and how we do it is part of the healthcare industry. Nursing programs have FAR more documentation requirements than are required here.

#4 - 5.1.1.12- deadlines for uploading should extend to 14 days. Also, days need to be defined, business or calendar?

5.1.1.12.1.1- has this be approved by TCSG from the Department side? Perhaps a joint letter from TCSG approving such a rule would be bets.

5.1.1.12.2 and 5.1.1.12.3- these forms should be merged into one file form or forms. Since they are going into the same location, why the separate forms.

Response- The FERPA form was sent to TCSG and they agreed it was acceptable. Merging of the forms will be considered.

#5 - Not clear as to what needs to be done in case a students goes longer than 10 days finishing course requirements

Response- This will be clarified in the revised policy.

5.1.2 Curriculum

4 Comments:

#1 - Agreed - Suggest that programs provide a syllabus for each module. I have seen some programs that tried to get away with having one (1) syllabus for the entire course.

Response- Great point.

#2 - *** BIG ASK *** remove the "capstone field internship, which must occur after all core didactic, laboratory and clinical experience". For larger classes, it is not realistic to wait until the last minute to put all students back out on field internship for their capstone field internship. Doing this towards the end of the program is of course necessary but we need more time than what this statement would allow.

Response- This is required of all paramedic programs (CoAEMSP) – this will be reviewed for EMT/AEMT.

#3 - 5.1.2.1- Define appropriate sequence. Programs move their courses around as they choose. Otherwise, policy is not needed.

5.1.2.6- define a skills assessment system. Is this like platinum or Fisdap?

Response- See 5.1.2.2. Skills assessments include the vendors you mentioned.

#4 - Under Section 5.1.2.2. it states, in part, "Capstone field internship which must occur after all core didatic, laboratory and clinical experience."

The Capstone field internship should be the cumulation and final pieces of the internship portion of Paramedic Training. However, we want to ensure that this rule allows for classroom instruction to continue during the Capstone field internship. While the core didatic information has been taught, review material should be able to be taught in a classroom setting. This is important to prepare the student for both the Psychomotor and Written National Registry Exams. I have found that a time delay between the end of regular classroom discussion and taking these exams negatively impacts pass rates. If our Advisory Committee agrees with providing the Capstone field internship while we finalize classroom instruction and provide review materials, we want to make sure we are not in conflict with this rule.

Response- Yes, this would be allowed…but core didactic information must be taught prior to the capstone.

5.1.3 Self-Study Requirements

7 Comments:

#1 - This section states what a program must do for the self-study but when or how often it should be done is not mentioned. Is this an annual, per class, or 3/5 year self-study?

Response- Initially and likely on a 3-5 year basis – this will be clarified.

#2 - 5.1.3 - Suggest that new programs be allowed to proceed with courses under a Letter of Review (LOR)

Response- This will be considered.

#3 - Self-Study documents on proposed programs are usually performed after initial approval and prior to the granting of full accreditation. To request this of proposed programs will be significantly lacking in the data needed, since self-study reports require a significant amount of information. I would suggest that the department set up something like an application with provisional approval, that way the self study can be done during the class and set a timeline on the submission

Response- There will be some portions that are required before any course can occur.

#4 - Why is it noted that we must document our finances? What does that have to do with instruction? I understand asking for the materials and supplies we have, but financial information on a private, single-owned, business? This seems too invasive. I understand if we received government funding, but we do not receive any funding whatsoever.

Response- The policy says a "description of financial resources" – this is a description of where you get your money to conduct the training of the students – the description would not require ledger books. "Adequate Financial Resources" means that the entity is able to conduct and fund the program, including payroll, utilities, supplies, equipment, etc., without danger of the students being kept from attaining the desired educational outcomes simply because of a lack of sufficient funding.

#5 - Absurd and unnecessary requirement that may result in few instructors or schools offering programs in a time when ambulance services are putting non emt's on ambulances because they can't find any EMT's.

Response- The self study is a reflective process for the program to evaluate itself to determine if the program's stated outcomes are actually being met and the students are appropriately taught.

#6 - Please clarify if you will be requiring separate self studies for each program level (EMTB/AEMT/Paramedic) for each school or if 1 self study will include all programs. If multiple self studies are required do we have a template that you want us to follow as CoA does. And will all these be due at the same time or various times of the year. How often are they to be done (ie: yearly, every 2 years). And when is this set to begin?

Response- There will be a template in the license management system. The timeframe of completion will be clarified in the revised policy. The self study would encompass all levels taught by the program.

#7 - Self-study reports are required for all paramedic programs that are accredited. Listing out the requirements in 5.1.3.1 is redundant. Simply state that the program must comply with the most current accreditation guidelines and standards.

5.1.3.2- also redundant to accreditation policy noted above

5.1.3.3 et al- again, redundant and listing should be bullet pointed, not separate rule numbers

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Response- This policy also addresses EMT/AEMT programs.

5.1.4 Fair Practices

6 Comments:

#1 - 5.1.4.1.6.1- 5.1.4.1.6.3.2.3: I do not believe that giving these numbers to the public for potential students is helpful to the students or the programs. With including the NREMT results (which is a great way to see a programs success) seeing the amount of students that show up to day one and do not make it is adding to much data to our webpage that could be hard to understand for a person not involved. I believe that the state office of EMS and the programs advisory committee can address issues associated with student attrition but not potential donors and potential students. These numbers should be available on request but not on the programs webpage.

I say this because a program that graduates 25/25 students does not show the success of the program but the results of passing the NREMT exam do. A program that has an attrition rate of 25% would show that it is actually graduating competent EMTs, AEMTS and Paramedics. But as a lay person this would seem that it is harder to pass the class and would gear students to attend the "easier" programs that may not be creating the most competent EMS professionals.

Response- Showing these numbers allows for full transparency for prospective students.

#2 - In 5.1.4.1.4 what do you mean by make available to the public. How and when should this information be made available to the public?

Response- On a webpage.

#3 - If you want everyone to become accredited, then just say it instead of making everyone have the same standards of being accredited without getting the benefits of being accredited. If you want everyone to run the school the same way, then don't let private schools operate. Leave the education up to public colleges and continue to see your EMT numbers drop. There is a reason why many students prefer private EMT schools.

Response- As was noted above, the 2020 EMS Strategic Plan, the program approval process is based on accreditation standards. Requiring all programs (private and non-private) to have increased standards and to appropriately prepare students to enter the workforce will only INCREASE the number of EMS personnel available for the workforce.

#4 - All of these are required with Technical Colleges and redundant to place in a rule as it is already required.

All accredited programs are already required to publish Paramedic outcomes by CoA. This is redundant.

5.1.4.2- this rule is redundant with regards to discrimination

Response- CoA only requires publishing of paramedic numbers – this would require EMT/AEMT numbers as well.

#5 - I can see this for Technical College programs that are accessible to the public and compete for public candidates, but not for inter-departmental classes that are not accessible to the public nor charging for classes, only training department personnel.

Response- Thank you for this comment.

#6: Agreed – No Comment.

5.2 Site Visits

4 Comments:

#1 - Again, if you want everyone to act as if they are accredited without receiving the benefits of being accredited, just say it. Why would we need site visits from an accreditation office staff member when we are not accredited? When EMT and AEMT courses don't even need to be accredited? I understand from our state district office that actually approves our courses, but why by national accrediting organizations?

Response- As was noted above, the 2020 EMS Strategic Plan, the program approval process is based on accreditation standards. Requiring all programs (private and non-private) to have increased standards and to appropriately prepare students to enter the workforce will only INCREASE the number of EMS personnel available for the workforce. This policy does not say that an external organization is coming – but if they are (like CoA, SACS, etc), then the Department's Regional EMS Training Coordinator must be invited to attend.

#2 - The Department has always had the ability to come to any class or school and monitor. The Department already has access to all of any data they wish to view. Why would a site visit be necessary by schools that are governed within the Department?

Response- To ensure compliance with this policy.

#3 - 5.2- Site visits should align with National Accreditation visits so as to not create an extra burden on the program since they are labor intensive. Or, accept the accreditation visit report and save time and a visit. This is redundant.

Response- For programs that are accredited by CoAEMSP, DPH personnel will come with the CoA team to do the site visit – CoA is only focused on the paramedic program, but DPH would also focus on the EMT/AEMT programs. For those programs that are accredited by CoAEMSP – there would not be separate site visits unless needed due to an investigation.

#4: Agreed – No Comment.

5.3 Data and Substantive Change Reporting Requirements

7 Comments:

#1 - Programs not meeting the established thresholds (70% retention and 70% pass rate on the NREMT cognitive exam with 3 attempts).

I believe we should keep programs accountable for pass rates, I do not think keeping up with retention rates is productive to our profession. Our EMT program is constantly below 70% retention rate because the student does not have a clear idea what we do and what is required to do this job with professionalism. If a student tells me they do not what to be in my class after seeing a bad car wreak , I do not ask them to stay. Our students our given one chance to pass their final exams if they fail another final exam during the course they do not continue in the course and will have to start the program over from the start. Unlike some programs that allows a student to take the same final three times to help keep their retention numbers it is doing nothing to help the public we serve and the student success as a provider. You will have programs that keep students that should be kicked out or failed out just to keep their retention rate above 70%. Please reconsider the retention rates for EMT and AEMT. Thank you

Response- The thresholds for EMT and AEMT will be updated.

#2 - While it would be good to have a retention of 70% and a pass rate of 70%, most programs at the EMT or AEMT level may struggle with this, since you can have the best program in the world but still not have a exam pass rate of 70% or greater. It may be a better metric to have a graduate rate then a job placement rate, since the job placement rate will speak to the passing of the NREMT. Because if you do everything you can, but you still cannot get a pass rate of 70% on NREMT, there isn't really much you can adjust. There should also be parts of the retention rate that do not negatively affect the institution like financial difficulties for the student or the student having some type of emergency. These are outside of the span of control for the institution.

It may be better to implement a post-course review form to gauge the effectiveness of the program as administered by the department.

Response- The thresholds for EMT and AEMT will be updated.

#3 - Again with the same accredited requirements. Also, when will schools start to get put on probation for not meeting these thresholds? How will these thresholds be kept up? Also, what about Covid? Our school saw many students start over the program or drop the program because of complications with covid, more so than any other year. Will this be accounted for?

Response- If a program consistently is graduating students that are not prepared for the NREMT exam or entry into the workforce, why would the program keep doing things the same way and not be required to have an action plan for improvement? We understand the

issues related to COVID, and that can be explained. It is important for a program to be transparent about the likelihood of a prospective student being able to go through the program and be successful.

#4 - Another CoAEMSP paperwork drill. The Department already has access to said data. Why not just publish the data on the LMS

Response- Prospective students need to review it on your website. LMS is not able to show this data.

#5 - 5.3.1.2.3. Last time I checked the first time pass rate for NREMT was only 67% , so having a policy that states 70% or better to achieve the threshold will mean that many programs will be having to come up with plans to increase to meet that threshold. Not that I am in opposition to keeping the numbers up but I also don't want to see it be punitive when a large number can't meet that threshold. I would recommend changing to 65%.

Response- The thresholds for EMT and AEMT will be updated. If a program is not able to meet the thresholds, then the program will need to explain why that is. The threshold are not meant to be punitive, but more informative. It allows for their to be a goal – if the program is not reaching the goal – the program should assess why that goal is not being met.

#6 - Annual reports should align with the most current National Accreditation guidelines and policies. Adding verbiage to this entire rule is redundant since all of the data is the same as CoAEMSP.

Response- This policy addresses EMT and AEMT as well.

#7: Agreed – No Comment.

5.4 Disciplinary Action

2 Comments:

#1 - Is each school separate, or are they all now public and under state control? Do business owners have any say if this gets passed?

Response- All EMS initial education programs are regulated by DPH.

#2 - If referring to programs other than paramedic, then appropriate. Since paramedic programs must be accredited for graduates to test the NREMT, seems redundant to state this.

Response- This refers to the regulation of all programs by DPH.

#3: Agreed – No Comment.

Additional Comments on this Policy

13 Comments:

#1 - Could there be a statement somewhere to the time frame to submit a new program for approval.

Example: 30 business days.

Response- This will be considered.

#2 - Lots of great stuff in here... Please please allow a "transition period" to allow us to really drill down and get this right at the program level.

Response- A transition timeline will be included in the revised policy.

#3 - When the Paramedic programs were tasked with preparing for CAAHEP Initial Accreditation, we were given ample time to submit our self-study and begin implementing the items found to be lacking. I am in hopes that ample time will be afforded to the programs not currently holding National accreditation, to meets the requirements of this policy.

Response- A transition timeline will be included in the revised policy.

#4 - While I believe that some of the changes in this policy are warranted because we have acted under no supervision for so long the change needs to be more gradual. As a doctoral candidate in the field of education with extensive knowledge of accreditation processes, this policy seems to support the OEMS/T as more of an accrediting agency other than an oversight agency. The fear is that if the department does not have educationally qualified personnel that are overseeing this process as well as staff to assist the institutions, specifically at the EMT/AEMT level, the only programs that will continue to exist are ones that are administered by educational institutions.

While this is a good attempt, I believe a more gradual approach will be better suited to serve the EMS community in GA, but this is to much too fast.

Response- A transition timeline will be included in the revised policy.

#5 - It appears these rules and guidelines were written for education programs that train the general public for a fee/tution. A many of them are appilcable for programs that educate their own employees.

Response- This policy in its final form (it is just draft right now) will apply to all programs.

#6 - My biggest concern is the added Medical Director responsibilities. This is all good for a small program or a small paramedic program. However, this could quickly become cost-prohibitive and could make it much more difficult. We need to find a balance where we have more Medical Director involvement but not at the point where you need a full-time physician on staff. I hope you understand that most of these physicians are treating patients during the weekdays during office hours and they have limited hours. I am lucky to have a great Medical Director that is there for us a lot and participates in lectures, skill checks, and policy review. However, she would not be available full-time.

Response- Please see responses above regarding medical directors. It is understood the limits on the time of physicians, but programs must have appropriate clinical oversight by physicians. There is NO requirement or expectation for the medical director to be full-time and the responsibilities of the medical director in this policy do not lead to a medical director needing to be full-time. If you already have a medical director that “is there for us a lot”, then these requirements should be very easily attainable.

#7 - Don't complain about an even larger lack of EMTs when you require these changes to happen. Small businesses and private schools are about to have nothing to set them apart. It looks like more and more things will be decided by the State instead of each institution. There are reasons why some students prefer tech schools and why other prefer private.

Response- This policy sets minimum standards for all programs, and does not presume or prefer students to attend one type of program versus another.

#8 - Credible Education Through Accreditation is the motto of CoAEMSP and truly the spirit behind this draft. Meanwhile, CoAEMSP doesn't really actually do any education (they make no claims that they do), they just generate administrative polices and procedures that choke the life out of everything it comes in contact with. Why the Department would model new policies after such a unsustainable system is beyond me. If the public could be made to understand what happened to all these paramedic programs there would be outrage. Then if they could understand that the same is happening to EMT programs, there would be outrage.

Ambulance services primarily wanted paramedics to work on their ambulances, CoAEMSP has not delivered and they have had almost 10 years. Now ambulance services would be happy to just get some EMT's and AEMT's to work on their ambulances.

An EMS workforce study was completed in 2007 by the Georgia Senate (https://www.senate.ga.gov/sro/Documents/StudyCommRpts/07EmsRetainRecruitRpt.pdf), have you read it?

Response- The goal of this policy is to set standards for EMS initial education programs. In order to develop a sustainable workforce for the future, the first step is to bolster the educational pipeline. In Georgia, since 1/1/2019, for the EMT level, there have been 4638 graduates to have attempted the NREMT exam. Of those, 920 (20%) have not completed the exam. This means that there are 920 people out there that have completed a program but have not been able to pass the NREMT exam. It is also noted that some programs have cumulative (6 attempt) pass rates on the NREMT exam in the 40-50% range. These are some of the numbers that we are trying to address. The public would be interested to see the disparity in EMS initial education programs – this policy will help address some of those disparities.

#9 - All sections are clear, concise, and fair.

Response- Thank you.

#10 - Give us time to work on this. I actually submitted comments earlier and added a few things after rereading the document. There is A LOT in here and we need time and resources to get this right. Perhaps a goal of January 2022? This would allow us to get it right and not rush as well as add items to our 2022 budget that would assist in this process.

Response- A transition timeline will be included in the revised policy. There is no expectation that all programs would be able to meet this immediately.

#11 - What if any conversations have been had with TCSG regarding these changes? Many programs are small and have a very limited number of personnel and you are asking us to increase our work load substantially. When we go back to our administration they often say that we cannot or will not hire any more people to assist. And we are already barely keeping our heads above water now. It would be helpful if TCSG were on board with the changes and could actively speak with the colleges and advocate for what we need in order to get this done.

Response- TCSG programs were included in the dissemination of this DRAFT policy – which is just one of the first steps.

#12 - These rules should have been worked though by a panel of program coordinators and instructors. There was no rules workshop to provide immediate feedback and dialogue for consensus. In addition, these rules were posted blindly on the website and not immediately shared with the organizations.

There is a fair amount of errata in the document such as heading structure, rule numbering and bullet-pointing.

Response- This public comment process is new for policies, and while not required, the public comment process has proven very useful to get feedback from various stakeholders. The policies were shared with ALL interested stakeholders in a central location in DRAFT form on our website.

#13 - Understanding the drive to make a better Educational Foundation is paramount. But keep in mind that inter-departmental service classes are needed to meet the employment need of rural agencies. These agencies are limited in funds and personal for which most are having to serve dual rolls. These classes allow volunteer first responders and fire personnel in our department to get training and possibly gain employment with our service. Most are unable to financially afford Technical College programs. Some of the proposals work great for larger public education centers, but go beyond the capabilities of smaller inter-department programs. Georgia EMS employment is in a critical shortage as Governor Kemp has already issued an Emergency proclamation recently. I feel this will squeeze out many of the great programs initiated by GAEMSA grants.

Response- This policy is not meant to burden programs, but is meant to set minimum standards for programs and to bolster the educational pipeline to develop a sustainable workforce. This policy is not meant to deter any grant funded courses from occurring, but it is meant to outline the minimum standards for programs.