EMT-A Task Force Reviews Program

The State of Maryland is a national leader in the delivery of prehospital emergency care. An important aspect of this system is the training provided to volunteers and career providers of emergency medical services.

By the passage of the National Highway Safety Act of 1966, the U.S. Department of Transportation placed an emphasis on EMS. One of the more significant results of their efforts was the development of the Emergency Medical Technician-Ambulance (EMT-A) training program.

Maryland was one of the first states to initiate formal EMT-A training over a decade ago. Since that time, many tens of thousands of providers have received this training within our state.

For the past several years, the Department of Transportation has been working on and has just recently finalized the first major revision to the national EMT-A program.

Last year, the major advisory body on the Maryland EMT-A program, the MIEMSS Director's EMS Prehospital Advisory Committee (DEMSPAC) recommended that a study of the EMT-A program be made to determine what changes would provide the best and most practical program.

Dr. R Adams Cowley responded to this recommendation and he appointed a 19-member Task Force, chaired by Prince Georges County Fire Chief Jim Estepp, to develop recommendations to enhance Maryland's EMT-A program. The Task Force report was finalized and submitted to Dr. Cowley late last month.

The major findings and recommendations of the Task Force are reprinted in this issue of the *Maryland EMS News*, along with a summary comparison of the current and proposed EMT-A program.

Your comments and suggestions regarding the Maryland EMT-A program and the Task Force recommendations are requested. Written comments can be mailed directly to me in Baltimore or to any of the MIEMSS regional offices. Additionally, public hearings will be conducted during the last week in November at six locations.

After these comments have been received, a special DEMSPAC meeting will be held to review all the recommendations and input received. From this, we hope to be able to reach consensus on the future direction of the EMT-A program.

Our target date for implementing any consensus recommendations is July 1, 1985.

In the meantime, the EMT-A program in Maryland will continue in its present form. No changes will be made during this current academic year.

Again, I encourage you to participate in the review of the Task Force report and to actively involve yourself in the comment process. Through this process, we hope to be able to implement a new and improved EMT-A program to better serve the needs of prehospital emergency care providers here in Maryland.

— William E. Clark
Director of Field Operations

Maryland
EMS
NEWS
Vol. 11 No. 3 SEPTEMBER 1984

Public Hearings Scheduled On Proposed Changes

Region I

Wednesday, November 28, 1984, 7 pm
Allegany County Civil Defense
EOC Office
Dorn Avenue, Ext.
Cumberland, MD

Region II

Thursday, November 29, 1984, 7 pm
Board of Education
Auditorium
823 Commonwealth Avenue
Hagerstown, MD

Region IV

Wednesday, November 28, 1984, 7 pm
North East Fire Co.
2105 Maulden Avenue
North East, MD

Tuesday, November 27, 1984, 7 pm
Peninsula General Hospital Medical Center
Hall Educational Center
100 E. Carroll Street
Salisbury, MD

Region V

Monday, November 26, 1984, 7 pm
MFRI Southern Maryland Regional Training Center
Radio Station Road — off Rt. 488
(next to LaPlata High School)
LaPlata, MD

Thursday, November 29, 1984, 7 pm
Laurel Vol. Fire Dept.
9th and Montgomery Sts.
Laurel, MD

Dr. Cowley Appoints Task Force

September 23, 1983

Chief M. H. (Jim) Estepp
Prince Georges Co. F. D.
County Admin. Bldg.—Rm. 2132
4318 Rhode Island Avenue
Upper Marlboro, MD 20772

Dear Chief Estepp:

While I recognize that Maryland is a national leader in the delivery of pre-hospital emergency care, and that we have the most advanced statewide emergency medical services system in the nation, I have a continuing commitment to assure that the best possible emergency care is provided to the Citizens of Maryland.

Daily we are faced with skillfully delivering this important emergency service. More than 300,000 emergency ambulance calls are handled annually by the volunteer and career providers in Maryland.

With the passage of the National Highway Safety Act of 1966, the U. S. Department of Transportation placed an emphasis on EMS. One of the most significant results of this was the development of the Emergency Medical Technician-Ambulance training course.

Maryland was one of the first states to embrace this training. Now, after nearly 10 years, we have gained great experience from this program. And the U. S. Department of Transportation is now in the process of finalizing a major revision to their EMT-A program.

The Director's EMS Pre-Hospital Advisory Committee, formerly known as the Ad Hoc Committee, has unanimously recommended that we study the EMT-A program to determine what changes would provide the best and most practical program here in Maryland.

I am intensely proud of our pre-hospital providers. Because the EMT-A program is the backbone of our delivery programs, and because I want us to continue to have the best program in the nation, I am appointing a Task Force with you serving as Chairman to develop recommendations to enhance Maryland's EMT-A program.

To help you in your deliberations, I will be placing special resources at the disposal of the Task Force to assist in carrying out your important work.

I hope that the Task Force will be in a position to make recommendations to me by March 1, 1984 so that the appropriate steps can be taken without delay. My staff stands ready to assist the Task Force in its deliberations and I appreciate your willingness to serve.

Sincerely,

R Adams Cowley, M. D.
Professor of Thoracic and
Cardiovascular Surgery

EMT-A Task Force Committee

Chairman

Chief M. H. (Jim) Estepp
Prince Georges County Fire Department
Metropolitan Fire Chiefs of Maryland

Vice-Chairman

Leonard T. King
Maryland State Firemen's Association

Members

Frank T. Barranco, MD
Field Medicine

Mary Beachley RN
Regional Emergency Medical Services Advisory Council

William E. Clark
Director of Field Operations
MIEMSS

Alasdair Conn, MD
Medical Director, Field Programs
MIEMSS

Robert N. Dempsey
Maryland State Firemen's Association

Bureau Chief James I. Mundy
Maryland Council of Training Academies

Charles W. Riley
Maryland State Firemen's Association

John W. Hoglund
Director
Maryland Fire & Rescue Institute

Albert Henley
Maryland State Ambulance & Rescue Association

James Miller
State EMT Evaluator

Dan Morhaim, MD
Field Medicine

Chief Paul Reincke
Baltimore County Fire Department
Regional Planning Council

William Gordy
Maryland State Firemen's Association

Leon Hayes
Regional Emergency Medical Services Advisory Council

Richard Enfield
Maryland State Firemen's Association

Joseph R. Robison
Maryland State Firemen's Association

Robert Wheeler
State EMT Instructor

Final Report: EMT-A Program Task Force

August 27, 1984

R Adams Cowley, M.D.
Director of MIEMSS
University of Maryland
22 S. Greene Street
Baltimore, Maryland 21201

Dear Dr. Cowley:

In your letter dated September 23, 1983, you appointed a 19 member Director's EMT-A Task Force, chaired by Chief Jim Estepp, to provide an advisory forum of the representative field providers, instructors, and the certification agencies involved with the EMT-A program.

The charter given to us was to study the Maryland EMT-A program to determine what changes needed to be made to provide the best and most practical EMT-A program. Appropriate recommendations were requested. Consistent with the work of similar task forces, not every item during the period of discussion met with everyone's approval, but overall, the report is a consensus of the findings of the committee and final approval was given by a majority of the committee.

We, the members of the task force, are pleased to present you with this report which represents our recommendations enhancing Maryland's EMT-A program as chartered.

Sincerely,
Chairman, M. H. (Jim) Estepp
Vice-Chairman, Leonard T. King
and other members of the Task Force

Editor's Note: The "Final Report of the EMT-A Program Task Force" is reprinted here unedited. It is reprinted in its entirety except for minutes of various meetings and related information which are not reproduced here because of their length.

I. ORGANIZATIONAL STRUCTURE, APPROACH, AND METHODOLOGY

A. Organizational Structure

The Task Force established three subcommittees to concentrate fact-finding efforts in three main EMT-A program areas of concern. They did not, however, limit the scope of their fact-finding efforts to the issues relating to each area.

The three subcommittees are as follows:

1. Subcommittee on EMT-A Training Programs

The efforts of this subcommittee were directed toward resolving several issues:

- A problem exists in which students report that the EMT-A course fails to provide sufficient time to master the material. At the same time, jurisdictions and students cannot afford the cost and time to lengthen the course.
- There also appears to be a developing shortage of EMT instructors. This is reported to be partially the result of too stringent requirements to become an instructor.

Chairman: Leonard T. King, Maryland State Firemen's Association. *Members:* Mary Beachley, Regional Emergency Medical Services Advisory Council; Jim Mundy, Maryland Council of Training Academies; John Hoglund, Maryland Fire/Rescue Institute; Robert Wheeler, State EMT Instructor. *Alternate:* Gary Warren, Regional Emergency Medical Services Advisory Council (representing Mary Beachley).

2. Subcommittee on Testing, Certification, and Evaluation

The area of Testing, Certification and Evaluation is an area which causes tremendous concern due to the reported failure rate of students. Several issues this subcommittee was requested to investigate are:

- The level of expertise required of an EMT recruit to pass this evaluation appears to be extremely high.
- The high number of examiners is very costly.
- The disparity between the instructors and examiners is a continuing problem.

Chairman: Frank T. Barranco, M.D., Field Medicine. *Members:* William Clark, Maryland Institute for Emergency Medical Services; Richard Enfield, Maryland State Firemen's Associaton; William Gordy, Maryland State Firemen's Association; James Miller, State EMT Evaluator; Charles Riley, Maryland State Firemen's Association; Joseph Robison, Maryland State Firemen's Association.

3. Subcommittee on the Role of State Agencies in the Administration of the EMT-A Program

This subcommittee was formed because of the concern raised about the declining number of new and refresher-trained EMTs.

Another problem needing to be researched is that numerous requirements of state agencies prevent jurisdictions from training small groups as needed, such as replacement career employees.

Chairman: Leon Hayes, Regional Emergency Medical Services Advisory Council. *Members:* Alasdair Conn, M.D., Maryland Institute for Emergency Medical Services Systems; Robert N. Dempsey, Maryland State Firemen's Association; Jim Estepp, Metropolitan Fire Chiefs of Maryland; Albert Henley, Maryland State Ambulance and Rescue Association; Paul Reincke, Regional Planning Council. *Alternates:* Reggie Shephard, Jr., Regional Planning Council (representing Paul Reincke).

B. Consultant

Touche Ross & Co. has been hired to perform three main activities:
—Perform pre-meeting coordination, take notes during meetings, and publish and distribute the minutes soon after the meetings;
—Assist in the design and conduct of the survey;
—Help draft the Task Force's final report to the Director of MIEMSS.

C. Meeting Schedule

The original schedule established for the Task Force meetings was

bi-weekly Task Force meetings with the subcommittees meeting during the week in between. The meeting time and place was set at 6:30 p.m. at the Prince Georges County Administration Building in Upper Marlboro, Maryland.

Due to holidays, weather, and other factors impacting the original schedule, we met six times during the period from December 21, 1983 to April 26, 1984. The subcommittees adjusted their schedules accordingly.

D. Approach

Each subcommittee's responsibility was to develop its own approach to determine what the EMT-A program's major problems were within each subcommittee's area of concern. Possible solutions to those problems were to be identified as a result.

The issues raised by the subcommittees and their proposed recommendations to resolve those issues were presented to the rest of the Task Force members at the meetings. Each subcommittee presented an oral and/or written report relating what had transpired in the subcommittee meeting to the rest of the Task Force. The issues in question were either resolved immediately in the Task Force meeting or resolution was postponed until more information was made available for a later meeting.

Formal motions were made for recommendations to resolve all the current and outstanding issues and problems raised by the subcommittees. Formal recommendations were also made concerning the enhancement of the EMT-A program.

E. Survey

During the course of the fact-finding process, we decided that a survey should be conducted. The purpose of this survey was to provide the subcommittees with the opinions of four groups of people involved with the EMT-A program regarding the main issues and concerns we had with the present program.

Methodology

The survey divided into separate sections according to the four groups surveyed:

— Currently certified EMT-As
— Course instructors
— Individuals who did not complete the course
— Individuals who did not recertify

A sample selection process was then developed to select a statistically valid, representative sample from the total population for each group from all MIEMSS regions in the State of Maryland. The total number surveyed was 350 people.

We decided to conduct a telephone survey instead of one by mail for several reasons. First, the subcommittee on EMT-A Training Programs informed us that previous surveys conducted by mail experienced very poor response rates.

Other factors affecting our decision were that we were under severe time and cost constraints. A telephone survey, conducted by several callers in each region, was able to satisfy the time schedule.

Taking into consideration the need to keep costs to a minimum, while also acknowledging the importance of conducting an unbiased survey, we decided to use volunteers to conduct the interviews on the phone. These volunteers were not involved with the EMT-A program and therefore could be objective during the interview process. Their names were recommended by Task Force members.

The questionnaire was drafted by Touche Ross & Co. in order to keep the questions as objective and unbiased as possible. The final questionnaire was reviewed and approved by the Task Force. Touche Ross & Co. also gave the volunteer callers instructions on how to conduct the telephone survey properly and in a manner consistent with our objective of achieving unbiased results.

The responses were then tallied and the results were analyzed.

II. ISSUES, FINDINGS, AND RECOMMENDATIONS

The following is a summary of the major issues we addressed concerning the current EMT-A program in the subcommittee and Task Force meetings.

Along with each area of concern, any relevant information gathered as a result of the subcommittees' fact-finding activity is presented.

Our recommendations to improve the EMT-A program are presented in relation to the issues under consideration. The survey results are used in part to support these recommendations and are described in Attachment #1.

Issues of Concern

Issue #1a

There is a lack of standardized lesson plans for use by the instructors to teach the material required.

Findings

Standardized lesson plans are not presently in use.

Issue #1b

There is a lack of adequate feedback mechanisms available to better inform the student as to how well he is performing in the course, and to direct him back to where he failed and why. (NOTE: The term "he" shall be understood to represent either he or she throughout this document, implying no specific gender.)

Findings

(Included in recommendations)

Recommendations

1. Text, workbook, and instructor guidelines should be standardized and objective based. The *Emergency Care* textbook, third edition by Brady, should be adopted as the standardized textbook. The sponsoring agency's current instruction and testing mechanism should be enhanced by suggesting that standardized quizzes and tests referenced to the textbook be employed by all instructors.

2. End of course MIEMSS administered written exam:

The present written certification examination, with the retesting options, is good but a better feedback mechanism should be established. Specifically, a system is needed which would provide the student, along with his written score, a page number and paragraph in the textbook to restudy for each question missed.

3. An evaluation critique form should be given to the student if he failed the course in order to provide a feedback mechanism which indicates what area he needs to improve before retraining and retesting.

4. Teaching aids should be available in sufficient quantity and kept current to adequately support class needs.

Issue #2

There is insufficient knowledge on the part of the student regarding what he should expect of the EMT-A course, and how he will be evaluated on the practical examination.

Findings

Student tension is increased by not having knowledge of what is expected from him.

Recommendations

1. Diagnostic evaluation of EMT-A candidates should be conducted at the first class meeting for reading skills and comprehension. This is not intended to be exclusionary, but to be used for counseling purposes and as an instructor aid. This recommendation was developed to give students a way of evaluating their potential success realistically, and to assist the instructor in meeting his student's needs.

2. The instructor should provide (during class introduction) an overview of the testing, retraining, and retesting included in the EMT-A program. Each student should receive a practical skills objectives guide which will be the same as the pass or fail form to be used by the examiner as a check off during practical exam testing. This is the same form as discussed in issue #6's recommendation (h).

Issue #3

There is an insufficient number of instructors available to adequately teach the number of courses currently demanded. It was reported that the guidelines to become a certified instructor are too stringent which could be the reason for the shortage.

Findings

It was the consensus of the Subcommittees on Training Programs that the requirements of becoming certified and maintaining certification as an EMT-A instructor were found not to be too stringent.

Also, we do not think that there is as much of a shortage of instructors as might have been believed. This perception was probably created by the fact that geographical shortages are experienced. These are believed to be caused mainly by instructors not wanting to travel to teach in a jurisdiction other than their own. A slight shortage may be caused by lack of publicity on how to become an EMT-A instructor.

Recommendations

None addressed.

Issue #4

Fiscal constraints have prohibited the system from having an adequate number of examiners.

Findings

Overall, there is not found to be an inadequate number of examiners. However, geographically shortages do exist. Local jurisdiction testing may be available to alleviate this cost, but overall, little impact is believed to be effected in this area of responsibility.

Recommendations

None addressed.

Issue #5

Quality control of the instructor recertification process appears to be inadequate.

Findings

The instructors are able to recertify; however, they are not all evaluated the same because they may all belong to different sponsoring agencies which do not evaluate them by the same standards.

Recommendations

1. We encourage Dr. Cowley to recommend to the State Board for Higher Education that a mechanism be developed to identify instructors teaching for more than one agency and require input from all agencies to MICRB prior to recertification.

2. Recommend that MIEMSS interface with appropriate agencies to eliminate the need of annual CPR instructor certification.

Issue #6

Major problems have been experienced with lack of student motivation to complete the EMT-A course, a high drop-out rate, and student failure of the course.

Findings

The student failure rate is not as high as commonly believed. Statistics show that the student pass rate has been 91–92% over the past two years. The drop-out rate, however, is high with an average of 28% of the students dropping out.

We believe that a main cause of students failing is student anxiety and tension at the practical examination due mainly to the disparity between the instruction and evaluation of the course materials. There is a lack of uniformity in conducting practical exam evaluations and the students often find themselves caught in between the instructor and examiner methodologies. Since each instructor teaches differently and each examiner evaluates differently, the students are often judged with inconsistency which then adds to their anxiety of the practical exam.

In addition, the problem is compounded by the use of a different examiner at each of the five stations in the practical. The student then has to be concerned with five different examiners' personalities and subjective appraisal of skills.

We found the main reasons for students dropping out of the EMT-A course were work and family commitments.

Recommendations

In general, we recommend that the EMT-A program be restructured in a manner which is aimed at (1) improving student motivation to continue the course and (2) providing a more standardized approach to instruction and evaluation techniques to give the student a better chance to pass, while satisfying the National Standards for EMT-A programs. More flexibility should be provided with this new structure to allow the student more options to complete the requirements necessary to receive EMT-A certification.

The specific recommendations are as follows:

1. Adopt the 1984 national DOT EMT-A concept with the *Emergency Care* textbook, third edition by Brady, standard text with standardized lesson plans as stated in the recommendation made for Issue #1.

This includes ten hours of pre-hospital care field work or simulation as explained in the following recommendation #3.

2. Structure this 1984 National DOT EMT-A standard course into modules A and B.

The first part — Module "A" — consists of 57 hours of training, and includes a (MIEMSS Approved) Instructor administered written examination and practical evaluation.

The second part — Module "B" — consists of 43 hours of training and includes the MIEMSS written and practical examination.

The titles and minimum times required for each of the 33 course lessons (by Module), are listed in attachment #2, *"Course Lesson"* descriptions.

3. Require the ten hours of field internship to be a *"Local"* company-based program which must be completed prior to EMT certification.

4. Individuals successfully completing Module "A" would be certified as Emergency Care Technician (E.C.T.), for a period of three years, and would be eligible to enter the second part — Module "B" — for up to one year from the date of Emergency Care Technician certification or to recertify as a First Responder within three years from date of certification. In addition, these individuals would be able to provide basic Prehospital Emergency Care within the Maryland EMS system and gain valuable provider experience while serving in their "Local" EMS Program.

5. Provide a mechanism for the First Responders, Advanced Red Cross, and other Health Care Providers to enter the EMT-A training program at Module "B," upon successful completion of a "Challenge" examination equivalent to those conducted during lesson 19 of Module "A."

6. End of course MIEMSS administered practical exam:

a. The practical evaluation exam should be performed by those who are not the class instructors.

b. Those instructors used as examiners should have demonstrated the ability to produce successful classes.

c. The practical exam should be acceptable for interstate reciprocity.

d. MIEMSS should provide an on-site coordinator at all practical exams.

e. Five stations should be used to test the required skills.

f. Develop and implement a staggered start procedure for the practical exam.

g. One examiner should evaluate two students through all five stations.

h. Evaluation form:

(1) Develop a four-part form indicating pass or fail of skills objectives as determined by the examiner.

(2) Provide one copy for the class instructor.

(3) Give one copy to the class instructor and return to the student at the scheduled retrain class.

(4) Send one copy to the sponsoring agency.

(5) Retain one copy by MIEMSS.

7. MIEMSS and MFRI should develop a formal process to review students' practical evaluation forms to identify potential instructor or examiner problems. Any potential examiner problems should be handled by MIEMSS and any potential instructor problems should be referred to the sponsoring agency. (See recommendation to Issue #5.)

Attachment #3 is a summary of the proposed modular training program.

Issue #7

The retraining and retesting of students who failed are being conducted at an inappropriate time.

Findings

Presently, the retraining and retesting was conducted the same night the practical exam was given. We found that this procedure did not accomplish true retesting. Students would copy what they were just shown at the station(s) they failed in order to pass. They were not given adequate time to retrain properly to gain and retrain the proper skills to pass the practical station(s).

Recommendations

The following is a list of recommendations made to improve the retraining and retesting process:

1. During creation of the original class schedule, dates will be established for a retrain class and a retest class within two weeks of the completion of the end of course exam.

2. Failure of any station or stations

a. Retrain at regular scheduled retrain class.

b. Retest failed station at the regular scheduled retest class.

c. Failure of a station at retest:

(1) Retraining options:

(a) Sit for appropriate class covering failed station objectives.

(b) Obtain retraining by self-study.

(2) Retesting options:

(a) Test station failed to be retested at a scheduled practical exam site, space allowing.

(b) Perform skills for failed station in the presence of three examiners and receive their satisfactory sign-off.

d. This final retraining and retesting must be completed within six months of the original class practical.

Issue #8

There is an expressed need to have an optional reciprocity arrangement among local jurisdictions to use their own examiners for practicals.

Findings

MIEMSS developed draft guidelines for utilization of local examiners which were referred to Task Force by DEMPSAC and REMSAC in the form of Draft #1.

Recommendations

Allow sponsoring agencies to effect their own practical skills examination using the following criteria:

1. MIEMSS must be notified, prior to the practical, of the time and approve the location of the practical skills performance test.

2. The examiners may be from the same jurisdiction as the instructor or class and as a courtesy may be exchanged by jurisdictions for the purpose of administering the practical exam. MIEMSS should provide an on-site coordinator at all practical exams.

3. Must successfully complete MIEMSS Evaluation Workshop.

4. Must utilize an approved testing environment as designed by the local authority.

5. Must evaluate on approved standardized skills and in MIEMSS approved manner.

6. Examiners must certify that the evaluation was conducted in the MIEMSS approved manner.

Issue #9

The level at which the providers should be required to recertify was in question.

Findings

(included in recommendation)

Recommendation

Recertification should be completed at the highest level of training.

Issue #10

The national standard duration for EMT certification was two years.

Findings

(included in recommendation)

Recommendation

The three-year EMT-A certification period should be maintained.

Issue #11

The means of recertification for an EMT-A was questioned.

Findings

(included in recommendation)

Recommendation

MIEMSS and MFRI should confer and develop a standard care curriculum for self-study refresher course combined with the required amount of topical continuing education credits. This should be allowed to be used in lieu of the 21-hour refresher course.

The following is a suggested model: Complete a refresher course every three yers *or* complete six hours of a self-study refresher course and four hours of continuing education each year. At the end of three years — challenge written and practical examination; if fail, take refresher course.

III. CONCLUSION

In summary, we, the members of the Task Force, feel that there are several areas of the EMT-A program which can be improved. We believe that if our recommendations are implemented, we can help to make Maryland's EMT-A program a better one than what currently exists. A new image will be presented to the current and future EMT-As.

We hope that this enhanced program will allow the number of

certified EMT-As continue to grow, and that fewer students will drop out or fail. We also intend that the new program structure, both in instruction and evaluation improvements, will allow the EMT-As to be best equipped with the proper knowledge and skills to perform their job well.

This excellent performance is so critical to best meeting the needs of the community they serve in.

ATTACHMENT #1: SURVEY RESULTS AS THEY RELATE TO RECOMMENDATIONS

Below are several comments which highlight the important issues which elicited a strong response on the part of the people surveyed. Unless otherwise noted, the following attitudes were expressed by the majority in each group surveyed:

- The quizzes, mid-term, and final written exam were an appropriate measure of what they learned in class.
- Sufficient teaching aids were available. The instructors did not feel they were sufficient but agreed that the quality of aid was good.
- The Brady textbook adequately prepares students.
- The standardized quiz with the answers referring to the textbook is chosen to be the best feedback mechanism to the students.
- The instructors believed that the standard lesson plans would help students pass the exam, while also helping the instructors teach the course.
- The instructors thought the 110 hours would provide the EMT-As with the proper training.
- Most would like to have the practical exam given at the end of the course and not in the middle.
- In support of the modular course concept.
- The EMT-A course adequately prepares the EMT-A to function in the field. The instructors, however, had the opposite opinion.
- In favor of taking the field internship prior to testing.
- Most were in favor of taking the challenger examination to enter Module B.
- The practical was fair.
- The instructors believed that one examiner used for the five-station practical would increase student tension rather than decrease it.
- The certification period should be for three years.
- The recertification course provides enough retraining and meets the needs of the field providers. The instructors, however, did not share this same opinion. They felt that the recertification course was not adequate in length whereas the other people surveyed thought it was adequate.
- The two major reasons for not recertifying or not completing the course were: work and family commitments; class held at inconvenient time.

ATTACHMENT #2: PROPOSED "MODULAR" EMT-A COURSE LESSON DESCRIPTIONS (7/84)

COURSE LESSONS FOR MODULE "A"

EMERGENCY CARE TRAINING
PART ONE OF THE EMT-A TRAINING COURSE

1. INTRODUCTION TO EMERGENCY CARE TRAINING (3 HRS.)
   Overview of course objectives, scope, EMT roles and responsibilities, legal aspects of emergency care.

2. ANATOMY AND PHYSIOLOGY AND PATIENT ASSESSMENT (3 HRS.)
   Overview of human systems, including anatomy, physiology and an introduction and practice in patient assessment.

3. AIRWAY OBSTRUCTION AND RESPIRATORY ARREST (3 HRS.)
   Basic mechanics of respiration; signs of airway obstruction and respiratory arrest; maintaining an open airway; pulmonary resuscitation; variations for infants, children and laryngectomees.

4. CARDIAC ARREST (3 HRS.)
   Basic mechanics of circulation; signs of cardiac arrest; cardiopulmonary resuscitation by a lone rescuer and by a team of rescuers; variations for infants and children.

5. A. MANIKIN PRACTICE (CERTIFICATION OPTIONAL) (2 HRS.)
   This lesson when combined with lessons 3 and 4 should provide the student with sufficient practice to be certified in CPR to American Heart Association Standards.
   B. PRACTICAL USE OF AIRWAY ADJUNCTS (1 HR.)
   Use of airways, suction equipment, oxygen equipment and delivery systems, resuscitation devices. Special considerations in CPR.

6. BLEEDING AND SHOCK (3 HRS.)
   Basic mechanics of circulation; determining blood pressure; signs of shock; preventing shock; treating shock; signs of external and internal bleeding; controlling bleeding; performing an examination for life-threatening problems; taking blood pressure; additional practice on airway care; pulmonary and cardiopulmonary resuscitation; use of mechanical aids to airway care and resuscitation. (Instructor Administered Quiz.)

7. SOFT TISSUE INJURIES (3 HRS.)
   Anatomy and physiology of the skin, signs and significance of various wound types, basic care of wounds, dressing and bandaging wounds.

8. INJURIES TO THE CHEST, ABDOMEN AND GENITALIA (3 HRS.)
   Parts and functions of the abdomen, digestive system and genitourinary system; chest, abdomen, and genitalia; techniques of care; dressing and bandaging the chest; practice in performing a complete patient examination for life-threatening problems and injuries.

9. BLEEDING AND BANDAGING PRACTICUM

10. A. PRINCIPLES OF MUSCULOSKELETAL CARE AND FRACTURES OF THE UPPER EXTREMITY (1.5 HRS.)
    Anatomy and physiology of the musculoskeletal system; definitions and types of fractures and dislocations; signs and symptoms of fractures, dislocations and sprains; examining a patient for injuries; techniques of immobilizing fractures and dislocations of the upper extremity.
    B. FRACTURES OF THE PELVIS, HIP AND LOWER EXTREMITY (1.5 HRS.)
    Signs and symptoms of fractures and dislocations of the pelvis, hip and lower extremity; immobilizing fractures and dislocation of the pelvis, hip and lower extremity, practice in examining a patient for injuries and in the use of pneumatic counter pressure devices.

11. PRACTICAL LAB: FRACTURE CARE OF THE UPPER AND LOWER EXTREMITIES (3 HRS.)
Practice in the assessment and management of fractures of the upper and lower extremities.

12. INJURIES OF THE HEAD, FACE, EYE, NECK AND SPINE (3 HRS.)
Anatomy and physiology of the nervous system; signs and symptoms of spine fractures; general rules of caring for patients with spine injuries; signs of a skull fracture; caring for patients suffering from injuries to the skull, brain, face, eye and neck; practice in immobilizing patients on short and long boards. (Instructor Administered Quiz)

13. PRACTICAL LAB: PATIENT ASSESSMENT AND SPINE IMMOBILIZATION (3 HRS.)
Practice of patient assessment techniques and in the recognition and treatment of spine injuries.

14. MEDICAL EMERGENCIES (3 HRS.)
Causes, signs, symptoms and techniques of care for poison victims; victims of bites and stings; heart attack patients; stroke patients; patients suffering from dyspnea. Practice in CPR and mechanical aids to resuscitation.

15. EMERGENCY CHILDBIRTH (3 HRS.)
Relevant anatomy, physiology, terms and emergency care equipment; delivery and care of the baby and mother during normal and abnormal births; resuscitating the newborn; care of the premature infant; practice in simulated deliveries.

16. A. BURNS AND HAZARDOUS MATERIALS (1.5 HRS.)
Estimating the degree and size of a burn; caring for the burned patient; special dangers of different types of burns (heat, chemical, electrical, radiation); identification and recognition of hazardous materials situation and proper precautionary procedures.

B. ENVIRONMENTAL EMERGENCIES (1.5 HRS.)
Signs, symptoms and techniques of care for the patient suffering from heat cramps, heat exhaustion, heat stroke, hypothermia and frostbite; signs, symptoms and techniques of care for the patient exposed to water related emergencies.

17. LIFTING AND MOVING PATIENTS (3 HRS.)
Techniques of lifting and moving patients; immobilizing patients with suspected spine injuries on short and long backboards; loading and unloading stretchers; review of triage. (Instructor Administered Quiz)

18. AMBULANCE OPERATIONS (3 HR.)
Overview of regulations and recommendations pertaining to driving an emergency vehicle, provide an understanding of all records and reporting systems and forms utilized by the EMT and promote efficient and proper use of all radio communications equipment and systems the EMT will utilize.

19. MODULE "A" (STANDARD) WRITTEN EXAMINATION AND PRACTICAL SKILLS EVALUATION — "SIGN OFF" — BY COURSE INSTRUCTOR

END OF MODULE "A" 57 HOURS

COURSE LESSONS FOR MODULE "B" EMERGENCY MEDICAL TECHNICAN-AMBULANCE PART TWO OF EMT-A TRAINING COURSE

20. A. INTRODUCTION TO EMERGENCY CARE TRAINING REVIEW (1 HR.)
Overview of course objectives, scope, EMT roles and responsibilities, legal aspects of emergency care.

B. ANATOMY AND PHYSIOLOGY AND PATIENT ASSESSMENT REVIEW (.2 HRS.)
Overview of human systems, including anatomy, physiology and an introduction and practice in patient assessment.

21. A. AIRWAY OBSTRUCTION AND RESPIRATORY ARREST REVIEW (.5 HRS.)
Basic mechanics of respiration; signs of airway obstruction and respiratory arrest; maintaining an open airway; pulmonary resuscitation; variations for infants, children and laryngectomees.

B. CARDIAC ARREST REVIEW (.5 HRS.)
Basic mechanics of circulation; signs of cardiac arrest; cardiopulmonary resuscitation by a lone rescuer and by a team of rescuers; variations for infants and children.

C. MANIKIN PRACTICE AND CERTIFICATION REVIEW (1 HR.)
This lesson when combined with lessons 3 and 4 should provide the student with sufficient practice to be certified in CPR to American Heart Association Standards.

D. PRACTICAL USE OF AIRWAY ADJUNCTS REVIEW (1 HR.)
Use of airways, suction equipment, oxygen equipment and delivery systems, resuscitation devices. Special considerations in CPR.

22. INSTRUCTOR EVALUTION: PRACTICAL AND WRITTEN QUIZ (3 HRS.) (INSTRUCTOR ADMINISTERED)

23. A. BLEEDING AND SHOCK REVIEW (.75 HRS.)
Basic mechanics of circulation; determining blood pressure; signs of shock; preventing shock; treating shock; signs of external and internal bleeding; controlling bleeding; performing an examination for life-threatening problems; taking blood pressure; additional practice on airway care; pulmonary and cardiopulmonary resuscitation; use of mechanical aids to airway care and resuscitation.

B. SOFT TISSUE INJURIES REVIEW (.5 HR.)
Anatomy and physiology of the skin, signs and significance of various wound types, basic care of wounds, dressing and bandaging wounds.

C. INJURIES TO THE CHEST, ABDOMEN, AND GENITALIA REVIEW (.75 HRS.)
Parts and functions of the abdomen, digestive system and genitourinary system; chest, abdomen, and genitalia; techniques of care; dressing and bandaging the chest; practice in performing a complete patient examination for life-threatening problems and injuries.

D. REVIEW OF SHOCK AND INTRODUCTION TO PRACTICAL USE OF PNEUMATIC COUNTER PRESSURE DEVICES (MAST) (2 HRS.)
This lesson provides a review of shock, indications and contraindications in the use of pneumatic counter pressure devices and provides practice in their application.

24. A. PRINCIPLES OF MUSCULOSKELETAL CARE AND FRACTURES OF THE UPPER EXTREMITY REVIEW (1 HR.)
Anatomy and physiology of the musculoskeletal system; definitions and types of fractures and dislocations; signs and symptoms of fractures, dislocations and sprains; examining a patient for injuries; techniques of immobilizing fractures and dislocations of the upper extremity.

B. FRACTURES OF THE PELVIS, HIP AND LOWER EXTREMITY REVIEW (1 HR.)
Signs and symptoms of fractures and dislocations of the pelvis, hip and lower extremity; immobilizing fractures and dislocations of the pelvis, hip and lower extremity, practice in examining a patient for injuries and in the use of pneumatic counter pressure devices.

C. PRACTICAL LAB: FRACTURE CARE OF THE UPPER AND LOWER EXTREMITIES REVIEW (1 HR.)
Practice in the assessment and management of fractures of the upper and lower extremities.

25. A. INJURIES OF THE HEAD, FACE, EYE, NECK AND SPINE REVIEW (1.5 HRS.)
Anatomy and physiology of the nervous system; signs and symptoms of spine fractures; general rules of caring for patients with spine injuries; signs of a skull fracture; caring for patients suffering from injuries to the skull, brain, face, eye and neck; practice in immobilizing patients on short and long backboards.

B. PRACTICAL LAB; PATIENT ASSESSMENT AND SPINE IMMOBILIZATION REVIEW (1.5 HRS.)
Practice of patient assessment techniques and in the recognition and treatment of spine injuries.

26. MEDICAL EMERGENCIES II (3 HRS.)
Causes, signs, symptoms and techniques of care for diabetic patients, patients suffering from acute abdominal problems, patients with communicable diseases, poisoning patients, patients having seizures, pediatric patients, practice in patient assessment.

27. A. BURNS AND HAZARDOUS MATERIALS (1.5 HRS.)
Estimating the degree and size of a burn; caring for the burned patient; special dangers of different types of burns (heat, chemical, electrical, radiation); identification and recognition of hazardous materials situation and proper precautionary procedures.

B. ENVIRONMENTAL EMERGENCIES (1.5 HRS.)
Signs, symptoms and techniques of care for the patient suffering from heat cramps, heat exhaustion, heat stroke, hypothermia and frostbite; signs, symptoms and techniques of care for the patient exposed to water related emergencies.

28. PSYCHOLOGICAL ASPECTS OF EMERGENCY CARE (3 HRS.)
Considerations when dealing with special patients: infants, children, elderly, handicapped, psychologically disturbed; patients displaying abnormal behavior; substance abuse patients; dealing with death and dying; and emotional aspects of providing care as an E.M.T.

29. PRINCIPLES OF EXTRICATION (3 HRS.)
Principles and considerations involved in gaining access to and extricating persons from inaccessible situations; packaging and removing patients with suspected spine and other injuries; removing patients from beneath vehicles. (Instructor Administered Quiz)

30. AMBULANCE OPERATIONS II (3 HRS.)
Provide an overview of such aspects of EMT responsibilities as: vehicle and equipment maintenance, emergency department procedures, scene control, special scene situations (crime, death, etc.), disaster planning and other non-medical functions during a typical ambulance run.

31. SITUATIONAL REVIEW (3 HRS.)
Review of course contents by group discussion of situational examples.

32. FINAL WRITTEN TEST (2 HRS.)
Test of knowledge learned.

33. FINAL PRACTICAL EVALUATION OF SKILLS (4 HRS.)
Evaluation of skills learned in the emergency care course.

END OF MODULE "B" 43 HOURS

ATTACHMENT #3: SUMMARY OF PROPOSED MODULAR EMT-A TRAINING PROGRAM (7/84)

MODULE "A"

LESSON		HOURS	
1:	Introduction to Emergency Care Training	3	
2:	Anatomy, Physiology, & Patient Assessment	3	
3:	Airway Obstruction & Respiratory Arrest	3	
4:	Cardiac Arrest	3	
5:	Manikin Practice (certification optional); Practical Use of Airway Adjuncts	3	
6:	Bleeding and Shock	3	*
7:	Soft Tissue Injuries	3	
8:	Injuries to the Chest, Abdomen, and Genitalia	3	
9:	Bleeding and Bandaging Practicum	3	
10:	Principles of Musculoskeletal Care & Fracture of the Upper Extremity, Fractures of the Pelvis, Hip and Lower Extremity	3	
11:	Practical Lab: Fracture Care of the Upper & Lower Extremities	3	
12:	Injuries of the Head, Face, Eye, Neck & Spine	3	*
13:	Practical Lab: Patient Assessment & Spine Immobilization	3	
14:	Medical Emergencies	3	
15:	Emergency Childbirth	3	
16:	Burns & Hazardous Materials; Environmental Emergencies	3	
17:	Lifting & Moving Patients	3	*
18:	Ambulance Operations I	3	
19:	Instructor Admininstered Written Exam and Practical Evaluation Sign Off	3	

END OF MODULE "A" 57 Hours

**Instructor Administered Quiz*

INDIVIDUALS SUCCESSFULLY COMPLETING MODULE "A":

1. Will be certified as an Emergency Care Technician for a period of three years.
2. Will be eligible to enter a Module "B" course for up to one year from their date of initial certification as an Emergency Care Technician.
3. Will be able to function as a Prehospital Care Provider (Emergency Care Technician).
4. May receive credit (on an hour for hour basis) for Prehospital Care experience gained while actively affiliated with a Maryland (or other approved) Emergency Medical System Program.

MODULE "B"

PREREQUISITES

Individual must enter Module "B" during the first year of certification as an Emergency Care Technician and/or have successfully completed the "challenge examinations" within one year prior to entry into Module "B" course.

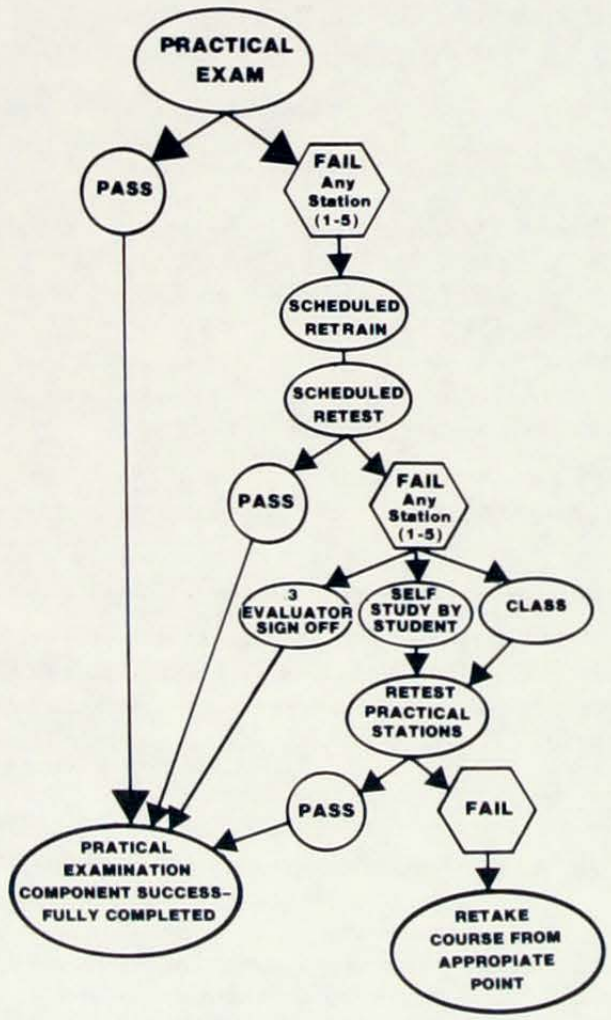
LESSON		HOURS
20:	Review: Introduction to emergency care training, anatomy, physiology, and patient assessment	3
21:	Review: Airway obstruction and respiratory arrest; cardiac arrest, manikin practice, and practical use of airway adjuncts	3
22:	Instructor administered practical evaluation and quiz	3

23: Review:	Bleeding and shock, soft tissue injuries, injuries to the chest, abdomen, and genitalia, and introduction to practical use of pneumatic counter pressure devices (MAST)	4
24: Review:	Principles of musculoskeletal care and fractures of the upper extremity; fractures of the pelvis, hip and lower extremity; practical lab: fracture care of upper and lower extremities	3
25: Review:	Injuries of the head, face, eye, and neck and spine. Practical lab: patient assessment and spine immobilization	3
26:	Medical Emergencies II	3
27: Review:	Burns and Hazardous materials, environmental emergencies	3
28:	Psychological aspects of emergency care	3
29:	Principles of extrication	3 *
30:	Ambulance Operations II	3
31:	Situational Review	3
32:	Final Written Examination (MIEMSS)	2
33:	Final Practical Evaluation of Skills (MIEMSS)	4
	END OF MODULE "B"	43 Hours

SUMMARY

MODULE "A"	=	57 hours
MODULE "B"	=	43 hours
Total Didactic & Practical Training		100 hours
"Company Level" Field Internship		+10 hours
Total Training and Company Internship		110 hours

ATTACHMENT # 4



CERTIFICATION AS ABOVE PROPOSED IS ALSO CONTINGENT ON THE STUDENT SUCCESSFULLY COMPLETING THE WRITTEN EXAMINATION REQUIRED FOR CERTIFICATION.

ATTACHMENT #5: GLOSSARY OF TERMS

Challenger Examination
An examination taken in order to test a person's knowledge of first responder skills. If this test is passed, then the person is allowed to enter Module B of the EMT-A course.

DOT
U.S. Department of Transportation

EMT-A
Emergency Medical Technician-Ambulance

Examiners
Refers to the evaluators who perform the practical exam testing.

Findings
The information gathered as a result of the subcommittee's fact-finding efforts concerning the issues.

Interstate Reciprocity
A person certified as an EMT-A in one state should be allowed to practice as a certified EMT-A in another state or be allowed to receive certification in another state.

Issues
These issues of concern are actually perceptions held by either the Task Force members or others involved with the EMS program and require investigation.

Jurisdictions
Local political jurisdictions; i.e. counties, city, state.

MFRI
Maryland Fire and Rescue Institute

MICRB
Maryland Instructors Certification Review Board

MIEMSS
Maryland Institute for Emergency Medical Services Systems

Modular Course Concept
The EMT-A course is separated into two course modules, each one designed to teach the students a different set of skills.

Module B
Second portion of the EMT-A program when taken in modular form.

Sponsoring Agency
An agency that funds and conducts a program.

Staggered Start Procedures
The starting time for a certain number of students to go through the practical exam is staggered.

Stations
These are the areas set up for testing different sets of skills within the practical examination.

Current EMT-A Program vs. Proposed Changes

Editor's Note: The following article, which is not part of the final EMT-A Task Force Report, outlines the current EMT-A program and the changes proposed by the Task Force.

INSTRUCTORS AND MATERIALS

Current

- Any EMT-A textbook meeting the objectives of the U.S. Department of Transportation National Standard Curriculum.
- No standardized lesson plans.

- Standardized quizzes and tests referenced to textbook not required.
- Up-to-date teaching materials are available in sufficient quantity to support class needs.
- Annual CPR instructor recertification required.
- No standard evaluation of instructors during recertification; each is evaluated according to standards of his/her sponsoring agency, but the Maryland Instructor Certification Review Board (MICRB) does not require input from each sponsoring agency on each instructor that the sponsoring agency employs.

INSTRUCTORS AND MATERIALS

Proposed

- Third edition of the *Emergency Care* textbook published by Brady adopted as standardized textbook.
- Standardized lesson plans.
  NOTE: The standardization of lesson plans will ensure that the content material is taught within the indicated lesson structure statewide, and therefore will be very useful in enabling a student to make up classes should he/she be unable to attend a scheduled class during the course of instruction. Thus, a student attempting to make up a class should not find himself with a group that is a lesson ahead or behind his class.
- Standardized quizzes and tests referenced to the text.
- Same
- Annual CPR instructor certification eliminated.
- Prior to instructor recertification, identification of instructors teaching for more than one agency required and input required from all agencies to the Maryland Instructor Certification Review Board (MICRB). MICRB will then use this input in determining whether an instructor should be recertified.

CURRICULUM

Current

- During the course, instructor explains testing, retraining, and retesting procedures for practical skills test but student cannot see the practical skills evaluation form prior to the test.

- No diagnostic evaluation of reading skills and comprehension to assist instructor in meeting students' needs.
- To become EMT-As, students have two options:
  (1) Take the 84-hour EMT-A course *OR*
  (2) Take the 40-hour First Responder course and then take the 54-hour Module "B."
  No internship or "challenge" mechanism currently exists.

CURRICULUM

Proposed

- During class introduction, instructor provides overview of testing, retraining, and retesting procedures, and gives the student a copy of the evaluation form used as a check-off during the practical skills test.
- During the first class, a diagnostic evaluation of reading skills and comprehension is conducted to assist the instructor in meeting students' needs.
- Present the U.S. Department of Transportation EMT-A standard curriculum in two modules. The total program consists of 33 lessons involving 100 hours of didactic and practical training plus 10 hours of "local" training (a company-level field internship training).

  The first part, Module A, consists of 57 hours of training, and includes a MIEMSS-Approved-Instructor administered written examination and

practical evaluation. An individual successfully completing Module "A" would be certified as an Emergency Care Technician (ECT), for a period of three years, and would be eligible to enter the second part, Module "B," for up to one year from the date of Emergency Care Technician certification or recertify as a First Responder within three years from the date of the ECT certification. In addition, the individual would be able to receive credit toward his/her field internship (on an hour-for-hour basis) by becoming actively affiliated with and participating in a Maryland (or other approved) EMS system program.

The second part, Module "B," consists of 43 hours of training and includes the MIEMSS written and practical examinations. In order to enter the Module "B" course of training, an individual must have successfully completed Module "A" and/or have successfully completed the *"Challenge"* (written and practical) examinations, which are equivalent to those conducted during lesson 19 of Module "A," within one year prior to entry into the Module "B" course.

Individuals who have successfully completed the MIEMSS written and practical examinations and who have obtained 10 hours of *"local"* training (a company-level field internship) would be certified as Emergency Medical Technicians for a period of three years.

Students wishing to move to the EMT-A level may choose to take the course of instruction one module at a time, stopping at Module A to become an ECT before becoming an EMT-A, or continue to complete Module B and become an EMT-A.

The proposed "Modular" EMT-A training program, if adopted, ***will not*** affect the established *Fire Fighter First Responder* training program in any way. This proposal will, however, provide a mechanism for the First Responders, Advanced Red Cross providers, and other Health Care Providers to enter the EMT-A training program at Lesson 20 of Module "B," upon successful completion of the "Challenge" examination process.

Editor's Note: The revised U. S. Department of Transportation (DOT) National Standard Curriculum is a result of input from EMS providers, trainers, and administrators nationwide. The revision was accomplished under a contract from the DOT National Highway Traffic Safety Administration that was awarded to the National Council of State EMS Training Coordinators. The revised and expanded National Standard Curriculum represents the realignment and expansion of the DOT-suggested standardized training program. Changes in the sequencing of lessons and the moving of material from one lesson to another have been minimal. The major changes in the program are the inclusion of MASTrousers as a basic life support skill, and the inclusion

of more designated practical skills training to allow for EMT-A candidates to develop the appropriate skills. The revision reflects the input of numerous individuals and their experiences with the previous DOT National Standard Curriculum. The newly revised curriculum has been accepted and is expected to be implemented in the majority of states.

LESSONS INCLUDED IN CURRENT EMT-A COURSE

1. Roles and responsibilities of the EMT, medicolegal aspects of emergency care, patient assessment, and vital signs.
2. Patient assessment and vital signs practicum.
3. Basic life support and respiratory system disorders.
4. Basic life support skills practicum.
5. Mechanical aids and oxygen therapy in basic life support.
6. Quiz — lessons 1–5. Circulatory system, wounds, bleeding control, and shock.
7. Wounds and injuries to the head and neck.
8. Wounds and injuries to the trunk.
9. Wounds to the extremities, bleeding control, and bandaging practicum.
10. Quiz — lessons 6–9. Injuries to the musculo-skeletal system.
11. Fracture management and splinting practicum.
12. Injuries and disorders to the neurological system.
13. Head and spinal immobilization practicum.
14. Quiz — lessons 10–13. Medical emergencies.
15. Environmental emergencies.
16. Mid-term examination.
17. Childbirth, pediatric emergencies.
18. Crisis intervention, behavioral emergencies.
19. Emergency vehicle operations, MIEMSS, communications, ambulance reports.
20. Quiz — lessons 14-19. Triage and disasters, moving and transferring patients practicum.
21. Phases of an ambulance call — skills development practicum. Patient assessment and vital signs; CPR, oxygen administration, and medical emergencies.
22. Vehicle extrication theory and patient skills practicum. Spinal immobilization and patient packaging.
23. Skills development practicum. CPR and oxygen administration. Fractures and bandaging and bleeding.
24. Practical skills review and preparation for practical examination.
25. Practical skills review and preparation for practical examination.
26. Final written review (practice exam).
27. Practical skills examination.
28. Final written certification examination.

LESSONS INCLUDED IN PROPOSED MODULAR EMT-A TRAINING PROGRAM

Module "A"

(See Attachment #3 on page 9.)

Module "B"

(See Attachment #3 on pages 9 and 10.)

TESTING AND CERTIFICATION

Current

- Written test and practical exam administered by MIEMSS.
- Feedback on written exam consists of scores on the six subsections without reference to any textbook.

- Evaluation of student's practical skills is available to him/her only on request.

- Class instructors cannot be evaluators during the practical skills exam of their class.
- Instructors used as examiners demonstrate ability to produce successful classes.
- Practical exam acceptable for interstate reciprocity.
- MIEMSS provides on-site coordinator at all practical skills exams.
- 5 stations used to test required skills.
- Staggered start procedure (in 2-hour intervals) for practical skills exam.
- Five examiners (one at each station).

- 1-part form indicating pass or fail of skills test.
- Evaluation form retained by MIEMSS. Copies given to class instructor, student, or sponsoring agency only on request.

- If a student completes the entire EMT-A course but fails to complete the EMT-A written or practical exam, he/she is not eligible for certification at any level.

- In an informal process, MIEMSS and the appropriate sponsoring agency review evaluation forms of students' practical exams to identify potential instructor or examiner problems. Instructor problems are brought to the attention of the sponsoring agency; MIEMSS handles evaluator problems.

- Sponsoring agencies (under proposed guidelines not implemented at this time) may administer their own practical skills exam using the following criteria:
  1. Prior to the practical skills exam, MIEMSS must be notified, and approve the time and location of the exam.
  2. Examiners may be from the same jurisdiction as the instructor or class and as a courtesy may be exchanged by jurisdictions for the purpose of administering the practical exam.

TESTING AND CERTIFICATION

Proposed

- Same

- Feedback on written tests consists of score and list of questions missed referenced with a page number and paragraph in the textbook so the student can restudy each section.
- Student routinely receives copy of his/her evaluation of practical skills if he/she fails the practical skills test.
- Same

- Same

- Same

- Same

- Same
- Develop and implement a staggered start procedure for practical skills exams.
- One examiner evaluates 2 students through all 5 stations.
- 4-part form indicating pass or fail of skills test.
- Two copies of evaluation sent to class instructor (one to be given to student at the retraining class); one copy to sponsoring agency; one copy retained by MIEMSS.
- If a student completes Module A, he/she will become an Emergency Care Technician. If a student completes Modules A and B and passes the written and practical exams, he/she will be certified as an EMT-A.
- In a formal review, MIEMSS and MFRI check evaluation forms of students' practical exams to identify potential instructor or examiner problems. Instructor problems are brought to the attention of the sponsoring agency; MIEMSS handles evaluator problems. The sponsoring agencies also forward information on instructor problems to the Maryland Instructor Certification Review Board (MICRB) which will consider this information when it decides whether an instructor should be recertified.
- Sponsoring agencies may administer their own practical skills exam using the following criteria:
  1. Same
  2. Same
  3. Same
  4. Same
  5. Examiners must use an approved testing environment as designated by the local authority, according to MIEMSS policies.
  6. Same
  7. Same

3. MIEMSS should provide an on-site coordinator at all practical exams.
4. Examiners must successfully complete the MIEMSS Evaluation Workshop.
5. Examiners must use an approved testing environment as designated by MIEMSS.
6. Examiners must evaluate on approved standardized skills and in MIEMSS approved manner.
7. Examiners must certify that the evaluation was conducted in the MIEMSS approved manner.

RETRAINING AND RETESTING

Current

- Retraining and retesting for persons failing one or two stations is done the same night as the practical exam. If a student fails this retest, he/she must take the 21-hour refresher course and retake the entire 5-station practical exam. Individuals failing three or more stations of the original practical exam are required to take a 21-hour refresher course within one year of failing the stations, and retake the entire practical. If the student fails this practical, he/she needs to repeat the entire EMT-A course.

RETRAINING AND RETESTING

Proposed

- When the original class schedule is established, retraining and retesting classes within two weeks of final course exam will also be scheduled. Students must take the retraining and retesting classes on these dates. If student fails retest, he/she has two retraining options and two retesting options. These must be completed within six months of the original class practical.

Retraining:

1. Sit for appropriate class covering failed station objectives *OR*
2. Obtain retraining by self study.

Retesting:

1. At a scheduled practical exam site (space allowing), the student will be retested on the test station that he/she failed.
   OR
2. He/she must perform the skills for the failed station in the presence of three examiners and receive their satisfactory sign-off.

RECERTIFICATION

Current

- A provider recertifies for each level of training.
- 21-hour refresher course followed only by a written exam is required for EMT-A recertification every three years.

RECERTIFICATION

Proposed

- Recertification of a provider should be completed at the highest level of training.
- A refresher course followed by a written exam every three years *OR*
  6-hour self-study refresher course and 4 hours of continuing education ***each*** year. Every three years the EMT-A will be required to take a written and practical skills exam. If the EMT-A fails, he/she is required to take the 21-hour refresher course.

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EMS Week Activities Slated Sept. 16–22

Numerous activities are scheduled for EMS Week (September 16–22) throughout Maryland.

Region I

EMS activities in Region I will begin with a proclamation of EMS Week by the Allegany and Garrett County Commissioners.

On September 15, the Country Club Mall will be the site of numerous EMS demonstrations and exhibits. The Maryland State Police Med-Evac helicopter will be on view and crew members will answer questions; divers from the underwater rescue team in Ridgely, WV and members of the snow rescue team in Western Maryland will also discuss rescue techniques. Three computers with EMS programs geared to EMTs, nurses and physicians, and the general public will also be available. In addition, the "Convincer," a seat-belt education tool used by the Department of Transportation, will be demonstrated.

Rescue and ambulance squads will host open houses and members will present talks in elementary schools to teach children how to use 911 to call for help.

A full-page newspaper article on EMS as well as radio public service announcements and a series of articles spotlighting EMT instructors and other EMS providers are also planned.

Region II

Ambulance companies in Region II will be participating in EMS Week by holding open houses, giving blood pressure screenings, and presenting talks in various schools. Jefferson Volunteer Fire Department will be presenting information on the vial of life program. Various EMS projects involving the media are also planned: the local chapter of the Emergency Department Nurses Association has done public service announcements on the prevention of pediatric injuries; an article on the development of EMS over the past 10 years is also being written.

Region III

Region III is planning to hold an exhibit of EMS services provided by the local jurisdictions at the Inner Harbor on September 22 between noon and 8 pm. Participants will include Anne Arundel, Carroll, Harford, Howard, and Baltimore counties, Baltimore City, the American College of Emergency Physicians, Raymond Curtis Hand Center, Johns Hopkins Pediatric Trauma Center, and Francis Scott Key Medical Center's burn unit.

Region IV

The Peninsula General Hospital Medical Center, with the cooperation of the Region IV office, is planning its annual trauma day symposium for September 15. The symposium will enable participants to further develop trauma management skills and to examine situations that one experiences at the prehospital and hospital levels of patient care. First responders, EMT-As, CRTs ATTs, nurses, physician assistants, and physicians are invited to attend.

Six continuing education units will be awarded to all Maryland certified CRTs who attend the symposium.

Those planning to attend the trauma day symposium are urged to register in advance. Registration forms and brochures may be obtained by writing to: Trauma Day Symposium 1984, Peninsula General Hospital Medical Center, 100 E. Carroll Street, Salisbury, MD 21801.

Just a reminder that the regional EMS skills competition will be held to coincide with EMS Week. All companies are urged to send teams to this first regional EMS competition. Also, those wishing to participate in the numerous EMS Week activities should contact their ambulance captains to find out what is scheduled in their area. Many Region IV ambulance companies are planning open houses, disaster drill exercises, and public awareness programs.

Region V

Region V EMS Week activities include skills competitions in several counties and a regional skills competition on September 23 at the Montgomery County Public Services Training Academy in Rockville. Prince Georges County will also have a countywide disaster drill. Activities in St. Marys County will be held September 22 in Lexington Park and include a demonstration of advanced cardiac resuscitation in the field, a blood pressure screening, and EMS exhibits. In many counties, EMS providers are also presenting talks to citizens groups.