

East Georgia Emergency Medical Services Education Consortium



Project Update
November 2nd, 2010

East Georgia EMS Education Consortium

The Paradox

- Medics Need to Be More Skilled
 - Greater Distances to Travel with Patients
 - Longer Time with Patients
 - Older Often Sicker Patients – More Equipment
- Fewer Training Opportunities in Rural Areas
 - Little Opportunity for “cutting edge” EMS Education
 - Expenses for Travel to Training Often not “Budgeted”

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- ❑ Shortage of Medics poses a Financial Burden – To County Governments, Hospitals
- ❑ Medics Often Resist Educational Opportunities
 - Many Medics Work Multiple Jobs
 - Training Opportunities (when available) interfere with “moonlighting”
 - Funds
 - Fatigue
 - Family

East Georgia EMS Education Consortium

- The Need
 - Accountability
 - Skills Degradation
 - Resolve “Distance”

The Project

- ❑ Terminal Objective was to improve skill competencies of EMS field personnel
- ❑ Five Rural Counties agreed to participate
 - Candler (Candler County EMS)
 - Emanuel (Emanuel County EMS)
 - Jefferson (Rural Metro Ambulance)
 - Jenkins (Jenkins County EMS)
 - Johnson (Johnson County EMS)
- ❑ One year project began in July 2009 and concluded in June 2010
- ❑ Service Directors had all committed to project

Initial Plan...

- ❑ Multiple medical education agencies had agreed to provide education material
- ❑ Initial plan was to tap into these resources and create “cutting edge” continuing education modules
- ❑ These education modules would be provided via internet with monthly visits to services for practical evaluations
- ❑ Initial efforts were dedicated to purchase of electronic equipment and setting up website

Initial Challenges

- ❑ Directors were not as responsive as they had agreed to be
- ❑ Collecting data for baselines was not easy due to lack of CQI programs
- ❑ Protocols were not being used (some employees had never seen them)



More Challenges



- ❑ Three of the five services were initially reluctant to provide me with PCR's
- ❑ Rural Metro was replaced with Gold Cross Ambulance in Jefferson County
- ❑ Patient care and documentation was sub-standard

Information Gathering

- ❑ Due to varying data collections procedures, collecting information on actual patient care delivered was very time consuming
- ❑ PCRs had to be read individually, info extracted and hand-entered into a (self designed) spreadsheet
- ❑ Picture was forming that standard practices needed to be improved before “cutting edge” education could begin

A New Plan Was Born...

- ❑ Data was collected for the Jan-June 2009 period to create a baseline for field care delivered
- ❑ The need for remedial training programs to address core knowledge and skills deficits was realized
- ❑ Dr. Griffin was brought on board to serve as an “outside evaluator” and steer the project
- ❑ All FT and PT personnel were initially expected to participate, but this was not mandated and could not be controlled
- ❑ Decision was made to mandate only FT staff

Total Participants = 61

- Candler County EMS
 - 10
- Emanuel County EMS
 - 16
- Gold Cross Ambulance Service
 - 8
- Jenkins County EMS
 - 6
- Johnson County EMS
 - 16
- Regularly participating PT personnel
 - 5

Written Baseline Evaluations

- ❑ All EMS Personnel were required to take a 100 question standardized baseline exam based on the individual's level of licensure
- ❑ Exam was taken "cold" with no opportunity to study
- ❑ Average age of workforce is 40 y/o, and most completed formal classroom training greater than 5 years ago
- ❑ Average Scores
 - EMT-I = 57%
 - EMT-P = 52%

Participation

- ❑ 232 participants attended
- ❑ 27 different education sessions
- ❑ 152.5 total in-person classroom hours were taught
- ❑ 32 on line hours were offered through partnership with Georgia OEMS
- ❑ 92% participating employees attended multiple training sessions
- ❑ 6.4% of participants were physicians and nurses from the Consortium service area
- ❑ The average size of classes was 9

Skills Deficits Identified

- “Assumption” prior to initiation of project was that intubation skills were poor
 - Could not confirm; skills observed in classroom setting and through CQI appeared to be above average
- The *actual* concern was non-aggressive airway management
 - 36% patients described to be in moderate to severe distress were not properly treated
- IV skills were assumed to be adequate
 - CQI and classroom observation showed IV skills to be sub-par

Areas of Greatest Concern

□ Patient Assessment

- Poor patient assessment was determined to be a universal problem across the board
- Poor patient assessments also appeared to be a major contributing factor in substandard patient care

□ Documentation

- Documentation was in great need of improvement, and could also be somewhat responsible for the *perceived* poor patient assessment and management

Areas of Greatest Concern, con't

□ No Transports

- Several services have no-transport rates of 40-50%
- Disturbing number of patients receive significant treatment (to include IVs, IV fluids, medication) and then have meds d/c's to obtain a patient refusal
 - Some of these patients have multiple IV sticks in attempt to establish patent IV for medication administration
- A very large number of the no-transports in some counties were patient under the age of 16 with no clear indication of why the parent does not want child transported

Additional Concerns

- ❑ 3 out of 5 Medical Directors have been uninvolved and unresponsive to our efforts to include/update them in our project and findings
- ❑ Effort to contact Medical Directors has been via e-mail, USPS, telephone, and through EMS Service Directors
- ❑ Some EMS Service Directors are not involved in, or compliant with project needs

Positive Outcomes and Improvements

- ❑ First half of project period was spent collecting data and designing education modules
- ❑ Second half of project period was spent teaching education programs (live classroom presentations)
- ❑ Field personnel were much more receptive to training that anticipated
- ❑ Field personnel expressed appreciation and enthusiasm for the programs delivered
- ❑ Had overall better response from field personnel than from EMS Service and Medical Directors

Positive Outcomes and Improvements

- During 2010 PCR review at end of project:
 - High flow oxygen was used more often
 - Albuterol treatments increased by 12%
 - CPAP use increased by 42%
 - Multiple unsuccessful IV attempts decreased by 21%
 - No-transports decreased by 7%

Some of these findings could be a direct result of improved documentation...

Year Two...

- Added three counties to the Consortium
 - Hancock
 - Washington
 - Screven
- Have struggled with two of the three
 - Hancock & Washington
- Consideration has been given to replacing these two counties
- Equipment has not been purchased, and will not be until decision is made

The Next Steps...

- Goals set for year two
 - Welcome new counties
 - Done
 - Dr. Griffin and I will visit each Medical Director
 - Not going well ☺
 - Only two MDs have been responsive (same two as always!)
 - Evaluate the prehospital drugs used in all eight counties and make standardization recommendations
 - Several drugs being carried are no longer recommended for prehospital use

The Next Steps...

- Modify existing Emergency Prehospital Care Protocols specifically for Rural EMS Providers
 - EMS Providers MUST be aware of, and follow protocols
 - Treatment plans in the field must be standardized and follow standard of care
- Design a workbook that includes a basic protocols test, skills check sheet, etc., that can be used for orientation *and* annual skills evaluations for employees in rural services
 - This has to be an on-going commitment from employers

Conclusion

- ❑ “Competency” should be fairly and clearly defined for the Rural EMS Provider
- ❑ A solid foundation for current scope of practice competencies must be assured before additional expectations or “nice to know” information is added/mandated
- ❑ Competencies must be measured upon entry (as an employee) and annually thereafter

Conclusion

- ❑ On-line classroom education is valuable, cost effective, and convenient...however
- ❑ To ensure competency, rural providers need at least one half of training hours in a classroom with direct oversight and observation by an experienced instructor
- ❑ Education modules should be directly tied to active CQI programs to ensure deficits are identified and corrected appropriately within a timely period
- ❑ CORE COMPETENCIES are a MUST!