The Growth and Development of an Educational Consortium
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ABSTRACT
This article discusses the beginning and continual evolution of a critical care educational consortium. Committee membership, curriculum development, and key service provisions are discussed. This article focuses on the process involved in the development of an educational consortium and the intended and unintended outcomes that developed as a result of this joint venture.

Health care delivery today requires a cost-effective, quality care focus and approach. Nursing departments across the nation are continually challenged to do more with less. A consortium is an alliance of like agencies that come together to jointly offer services or products to the customer. An educational consortium is one strategy that has provided opportunities to share resources and expertise. To be effective, consortia need to be able to continually evolve their structure and process so that quality educational outcomes can result.

The Capital District Region Critical Care Education Consortium (CDRCCEC) has a 4-year history of providing critical care education to nursing professionals in the Albany, New York, area. A standardized program reduces duplicate efforts by hospitals sharing resources and expertise.

The Consortium was started in 1991 after 12 area hospitals met to discuss the idea of combining resources and expertise to provide consistent education for new staff hired for critical care units. The Capital District has multiple hospitals in the immediate and outlying area that provide various critical care services for the community. Eight of the 12 hospitals contacted met for the first time in February of 1991 and began the planning process.

CONSORTIUM MEMBERSHIP
During the past 4 years, the membership of the CDRCCEC has undergone multiple changes. The original membership started with seven hospitals. The largest was a 674-bed tertiary care center, and the smallest was a 143-bed community hospital. Membership during 1991 was stable, and after the official course began in 1992, three more hospitals joined. In 1993, three additional institutions joined the Consortium. The next year brought even more change. Two hospitals stopped participating because they had a minimal number of staff attending the courses and the travel distance for meetings and classes was too great. Two other hospitals merged and converted to a single membership. The Consortium became an interstate endeavor when a Vermont hospital joined, bringing membership to 11 hospitals. The expanded and varied membership has only helped to increase the resources and, therefore, the quality of the programs offered.

COMMITTEE STRUCTURE AND MEETINGS
The first year required frequent meetings and planning sessions to organize the Consortium and plan the curriculum. Three committees formed the structure by which the Consortium work occurred.
The Administrative Committee met monthly to discuss services that each hospital would need to provide, letters of agreement, a co-sponsorship with the American Association of Colleges of Nursing (AACN), and membership expectations. The two curriculum committees, Critical Care Nursing and Emergency Nursing, held monthly all-day meetings to develop the curriculum. Each institution provided an administrative member and at least one curriculum member for the massive amount of work that needed to be done. Each of the three committees had a chairperson and a secretary. The curriculum chairs attended the monthly administrative meetings to report on progress. All this required a great deal of time, and each institution required the full support of their nurse executive. Many visionary mentors supported this project.

In 1992, the Administrative Committee began scheduling their meetings every other month. The Curriculum Committee formed task forces to look at test construction and course evaluation materials. By December of 1992, the two curriculum committees had merged and continued to meet monthly. Membership in each committee became smaller, with most institutions having one administrative member and one curriculum member (Figure). In August of 1994, scheduled meetings for both groups occurred every other month. The curriculum group met for 3 hours in the morning. Both groups networked together at lunch, and the administrative group met in the afternoon. Each hospital served as a meeting site on a rotation basis.

**CURRICULUM**

Curriculum development and revision continue to involve all members of the Consortium. Initial planning meetings determined that the program developed would be a beginning critical care course, thus the name Critical Care Essentials was selected. The outline for the course content was based on the *Core Curriculum for Critical Care Nursing* (Alspach, 1991). Realizing the complexity of staffing requirements, family obligations, and other personal commitments might make it difficult for people to attend a full course on consecutive days, the curriculum was developed in a modular format. By creating modules, class participants were able to structure their own program and attend the sections they needed, as well as complete them in a "building block" format.

Content on pediatric critical care and open heart surgery was not included in the curriculum because only three member hospitals offered these services. The original Emergency Nursing Course, also in a modular format, had 4 days devoted to adult emergency nursing and 2 days devoted to pediatric emergency nursing. This content is no longer in the curriculum, as other emergency affiliations in the area are now offering pediatric care courses.

Revision of curriculum is an ongoing process. Item analysis of examinations, course evaluations, and new care modalities impact the updating of the curriculum. Because all faculty members are either educators or staff members currently practicing in their specialty areas, the Consortium does not lack experts who are current and competent in their areas of practice. The input from all these experts provides rich resources and keeps the course on target with what is happening in the fields of critical care and emergency nursing. Each hospital is required to provide lecturers who are knowledgeable and aware of current teaching principles. Participant evaluations help monitor quality and discontinue use of any lecturers who do not meet standards.

**PROVISION OF SERVICES**

In addition to committee attendance, curriculum development, and provision of lecturers, hospitals
The Consortium is continually changing and improving its service to meet the needs of both the health care environment and the individual learner.

Provision of the room, audiovisual equipment, provision of participants, a short introduction in the morning, and collection of evaluations are part of the service. CE forms at the end of the day. Advertising includes designing, printing, and mailing the course brochure as well as keeping the mailing list current. The member hospital responsible for registration develops the registration form, sends the form to each member hospital, handles inquiries from nonmembers, and enrolls all participants.

Site site includes provision of the room, audiovisual equipment, registration of participants, a short introduction in the morning, and collection of evaluations and CE forms at the end of the day. Advertising includes designing, printing, and mailing the course brochure as well as keeping the mailing list current. The member hospital responsible for registration develops the registration form, sends the form to each member hospital, handles inquiries from nonmembers, and enrolls all participants.

Course Coordination includes confirming speakers and distributing the course schedule to all member hospitals. The member hospital responsible for CE Application applies for contact hours and completes CE certificates for each participant. Each member hospital is required to provide one major service, provide 40 hours of teaching per year, participate in curriculum development, and attend two-thirds of the administrative meetings.

As with other aspects, service definitions have changed and expanded. Originally, Course Materials included printing evaluations, tests, answer sheets, and CE forms, as well as printing and collating complete packets of learning materials for each attendee. This service no longer includes packet coordination and is now called Printing. The Course Evaluation service has been broken into two parts: speaker evaluation and test evaluation. After the first 2 years, it became evident that chairpersons of the Curriculum and Administrative Committees did a lot of work, and it was decided to designate each as a service. The newest service is a computerized database designed to better track attendance and course numbers. All of these services have been well defined in writing, so that each member hospital knows what the expectations are when they volunteer for a service.

As the Consortium membership grew and the frequency of courses offered increased, the need to change the membership requirements emerged. Some of the larger member hospitals could provide more qualified teachers and, therefore, were often teaching more hours. The smaller hospitals did not always have a lot of teachers but could provide more services. It was decided that additional teaching hours provided by a hospital would decrease their service expectation. Meeting attendance at both the Curriculum and Administrative Committees was still required by all because of the valuable input provided and the importance of all members having a vital role in Consortium activities.

USE OF INCOME

The first critical care course was held in the spring of 1992. Eight member hospitals composed the Consortium at that time. The average class size was 50 attendees. The fall 1992 course was marketed to the public. Fees covered costs by module or for the entire program. The course was offered three times in 1993 and opened to the public. By the end of 1993, enough income was available to buy one set of textbooks for each member hospital, as well as purchase the record-keeping software for the database program.

Because of the co-sponsorship agreement with the local chapter of AACN, the income was held for the Consortium in a separate account. The fee structure, evaluated in the spring of 1994, resulted in increased prices. Enrollment continued to be steady. The treasury is a healthy one which provided financing and enabled the Consortium to host a national critical care speaker for the community at a reasonable price in the spring of 1996.

CONTINUED DEVELOPMENT AND GROWTH

The CDRCCEC is continually changing and improving its service to meet the needs of both the health care environment and the individual learner. It has continued to grow as a service provider, as evidenced by requests from various groups for additional information.

An extremely enthusiastic interest continues to endure for the module on Basic Dysrhythmia Interpretation, one of the early modules. It is now offered three times a year and marketed to the Capital District area. For 1995, the Consortium again looked at ways to provide further education for nurses in the Capital District area and decided to offer some advanced teaching days and use earned income in a more effective way.
The first program featured two highly evaluated consortium educators who presented a program on “Diagnosis and Early Management of Acute Myocardial Infarction.” High attendance resulted at this program, so it was repeated again in the fall of 1995.

OUTCOMES

A member of the Curriculum Committee completed a research study that provided a summative evaluation of the effectiveness of the course. It queried how the participants felt they benefited from the course. When the study was completed, the findings were shared with members of the Consortium at the Administrative Committee meeting. The 52 RNs who completed the course reported a high level of satisfaction with the course and a moderate to high use of the content in clinical settings. A strong positive correlation was found between level of satisfaction and clinical application (King, 1994).

An analysis of salary cost savings addressed the Basic Dysrhythmia Interpretation course. If this content was offered on site, it would be completed in 2 days instead of 3 because of other learning modules already in place. However, if the department critical care educator did the entire program, estimated salary cost for preparation and lecture time would be approximately $1400. In the Consortium course, the educator teaches approximately 2 hours of lecture and assists with a 2-hour review class, so the approximate cost is $260. This is a major institutional savings as well as an efficient way for people to get more knowledge from other clinical experts.

A cost-benefit analysis comparing 1990 and 1995 costs for one hospital is included (Table). These costs are estimated, and the 1995 costs do not include the salary amounts for the critical care educator and administrator for attendance at the required committee meetings. These meetings are also used for planning advanced teaching days and networking, and cannot be compared with any factors of one critical care educator working alone in isolation in 1990.

Added benefits of the 1995 format include standardized critical care education for the community, continuing education credits for course attendees, and highly qualified educators from all member hospitals creating the curriculum. The multiple course offerings also provide more frequent opportunities for the course participants to begin clinical practice in the critical care setting.

An oncology education consortium began in the area after the success of CDRCC. A small group met and examined the feasibility of a management education consortium, but members in attendance identified that the level of learning needs of management at the interested institutions varied widely.

Another outcome of 5 years of working together is the networking and camaraderie that developed among the group members. The Consortium members have shared professional knowledge and resources on an ongoing basis and supported each other as institutions went through major changes and restructuring. Dinners have celebrated successful outcomes. All members have grown, both professionally and personally, from this experience.

IMPLEMENTATION SUGGESTIONS

Institutions and groups that wish to start an education consortium need to determine what resources are available in their geographic area. It is necessary to
evaluate such things as sites that will house large audiences, travel distances for intended participants, communication media for advertising, and class cancellation because of bad weather. Similar patient care centers need to come together so that a standardized curriculum can be developed to meet the needs of those institutions included. Key members, such as nurse executives and nurse managers, need to be included from the beginning. Without administrative support, each institution will not have the required capital or time to meet the consortium expectations. Letters of agreement should list the membership expectations clearly and should be signed by administrative staff. One contact person in each member hospital is essential for coordination of participant registration, textbook availability, and test completion, as well as for providing oversight for the delegated service expectation. Attendance at meetings is vital so the contact person has a clear understanding of expectations, time frames, and processes.

**SUMMARY**

Educational consortia continue to be one effective way to provide education through shared resources. It is important to continually examine ways to improve the product that is provided to customers and to increase the services offered for the community. Cost-benefit analysis demonstrates a 40% savings per student for the hospital analyzed. All members of the CDRCEC have developed new skills and new alliances because of this networking. Competent educators have been able to share their knowledge and expertise with a wider audience. This increased sharing of critical care education can only improve the delivery of care to the critically ill patient.

**REFERENCES**
