

**Assessment of SCoP Current Status (April, 2010)  
Against Criteria for Regulating a New Profession  
Established by the Ontario Health Professions Regulatory Advisory Council in 2005**

<b>HPRAC Criteria for Professional Regulation</b>	<b>Indicators of SCoP Current Status</b>
<p><b>1. Risk of Harm</b> A substantial risk of physical, emotional or mental harm to individual patients/clients arises in the practice of the profession.</p>	<ul style="list-style-type: none"> <li>• Early intervention and prehospital care has been shown to reduce harm</li> <li>• Paramedic interventions could certainly cause harm if practiced incompetently</li> </ul>
<p><b>2. Sufficiency of Supervision</b> A significant number of members of the profession do not have the quality of their performance monitored effectively, either by supervisors in regulated institutions, by supervisors who are themselves regulated professionals, or by regulated professions who assign this professions' services.</p>	<ul style="list-style-type: none"> <li>• No onsite supervision for most practice situations (eg. Ambulance, industrial site)</li> <li>• Protocol driven practice with reference to medical control required at clear decision points has been practice model and has worked well in ambulance setting. May not be appropriate for facility-based or industrial practice.</li> </ul>
<p><b>3. Alternative Regulatory Mechanism</b> Regulation under the RHPA must be a more appropriate means to regulate the profession than other means.</p>	<p>Ministry of Health was the regulator for many years.</p>
<p><b>4. Body of Knowledge</b> The members of this profession must call upon a distinctive, systematic body of knowledge in assessing, treating or serving their patients/clients. The core activities performed by members of this profession must be discernible as a clear and integrated whole and must be broadly accepted as such within the profession.</p>	<ul style="list-style-type: none"> <li>• Comparison of provincial scopes of practice to National occupational competencies profile (NOCP) shows consistent skill and knowledge requirements for the profession across the country</li> <li>• Core activities well established and accepted across the country</li> <li>• Evolution of profession into community and facility based practice is raising questions of both the range of activity and the protocol driven vs professional discretion/clinical judgment approach to scope of practice. Both have implications for future educational requirements.</li> </ul>
<p><b>5. Educational Requirements for Entry to Practice</b> To enter the practice of the profession, the practitioner must successfully complete a post-secondary program offered by a recognized educational institution. The educational program must be available in Canada.</p>	<ul style="list-style-type: none"> <li>• EMT-P: SIAST Diploma (2 years in addition to the EMT training); CMA accredited; similar programs in every province; match NOCPs</li> <li>• EMT-A: SIAST Certificate (1 year in addition to EMT training); not CMA accredited; unique to Saskatchewan; no NOCP to match</li> <li>• EMT: SIAST Applied Certificate (28 weeks); CMA accredited; similar programs in every province; match NOCPs</li> <li>• EMR: 80 hours in approved training (not recognized as post secondary); not CMA accredited but national programs exist (Red Cross and St. John Ambulance) which match NOCPs</li> <li>• Inclusion of EMRs is problematic – challenge is to frame it as entry point to profession which is the approach Alberta College of Paramedics (ACP) has taken.</li> </ul>
<p><b>6. Leadership's Ability to Favour the Public Interest</b></p>	<ul style="list-style-type: none"> <li>• CME – focused on need for continuing competency in situation where many members have little opportunity to practice on an annual basis; facilitators were influential in CME decisions; concentrated</li> </ul>

<p>The profession's leadership has shown that it will distinguish between the public interest and the profession's self-interest and in self-regulating will favour the former over the latter.</p>	<p>on implementation of regulatory bylaws. Mostly supportive feedback from field with some push-back based on lack of notice and cost. Incremental cost per practitioner will be experienced only by those services who did not have robust CME programs to start with, for others there could actually be a decrease in cost</p> <ul style="list-style-type: none"> <li>• Registration – required Criminal Record Checks of all members; 67 members had criminal records; one member's practice restricted as a result of CRC review</li> <li>• Over representation of SIAST instructors on Council was openly discussed and efforts were made to mitigate conflict of interest</li> <li>• Request from union to lobby for early retirement rights was denied by Council</li> <li>• Briefs to EMS Review and Patient First Review were based on research, analysis and evidence available to Council and were well received by both review commissioners as reflective of patient experience (Patient First Review) and as thoughtful advice (EMS Review)</li> </ul>
<p><b>7. Membership's support and willingness to be regulated and likelihood of complying with regulation</b></p> <p>The members of the profession support self-regulation for themselves with sufficient numbers and commitment that widespread compliance is likely. The practitioners of the profession are sufficiently numerous to staff all committees of a governing body with committed members and are willing to accept the full costs of regulation.</p> <p>At the same time, the profession must be able to maintain a separate professional association.</p>	<ul style="list-style-type: none"> <li>• Registration requirements met by all members; initial (2009) 30% incomplete applications rate reduced to 16% in 2010 registration; continued reliance on local facilitators to coordinate the process</li> <li>• Sufficient applicants for committee appointments for Council to select appointees who are capable and committed; some representatives have not been active</li> <li>• PCC – 18 complaints to date; all but one member cooperative with investigation; most resolved through CCRA; 2 licenses surrendered; conditions placed on 2 others, guidance letters sent in 3 cases, 3 referred to Discipline hearings, 6 complaints dismissed.</li> <li>• Substantial fee increase approved by AGM. Resolutions were provided to all members 3 weeks before AGM.</li> <li>• Attendance at the AGM was comparable to the proportion of members who attend the AGMs of other SK regulators.</li> <li>• Nominations committee is considering strategies to get more involvement from the EMR and EMT classifications on Council and committees, and during the elections of Council; 13 candidates for two positions in 2010 Council elections including women, EMTs and rural.</li> <li>• No Paramedic Association has emerged in SK.</li> </ul>
<p><b>8. Economic impact of regulation</b></p> <p>The profession must demonstrate an understanding and appreciation of the economic impact of regulation on the profession, the public and the health care system.</p>	<ul style="list-style-type: none"> <li>• SCoP has been criticized for both a substantial fee increase and the cost of changes to CME, particularly the 2 year cycle for mandatory certifications</li> <li>• Council phased in the ITLS requirement for EMTs over two years in recognition of the impact on the system.</li> <li>• Council and the AGM chose to phase out debt over many years rather than set the fee at an even higher level. SCoP believes that an appropriate balance has been achieved between adequately resourcing the regulatory role and the impact on the system. The overall impact of the fee increase (health, fire and industrial) is \$250 X 1900 members = \$475,000.</li> </ul>
<p><b>9. Public need for regulation</b></p> <p>The profession must demonstrate that a significant public need would be met through regulation.</p>	<ul style="list-style-type: none"> <li>• Access to ambulance service, rather than competence or capability in the back of the ambulance, remains the rural public focus leading to lack of support for SCoP in some parts of rural SK where</li> </ul>

	<p>regulation has been equated with loss of ambulance service. Challenge is to ensure competence of practitioners without decreasing service, and to educate rural SK on the role of the college and the benefit of quality assurance and competence of practitioners</p> <ul style="list-style-type: none"> <li>• Increasing economic activity in the province has also increased the need for paramedic services on industrial and mining/resource extraction sites. There is a public interest in regulation for those services.</li> <li>• New assignments for paramedics in facilities and community services need to be appropriately regulated. SCoP focus to date has been on the EMS practice. Challenge is to become familiar with and take a role in regulation of these other practices.</li> <li>• Fire Chiefs argue that the expansion of scope for EMTs is not necessary or helpful for the fire service. The medical dominance and lack of role for Fire in the scope decisions undermines the fire service's support for regulation and for SCoP. The challenge is to meet the fire service needs without undermining the regulatory framework or the progress which the health system wishes to make.</li> </ul>
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**Assessment against additional criteria suggested by College of Physicians and Surgeons of Saskatchewan**

<b>CPSS Criteria for Professional Regulation</b>	<b>Indicators of SCoP Current Status</b>
<p><b>10. A rigorous regulatory process</b> including adequate regulatory capacity and commitment to due diligence</p>	<ul style="list-style-type: none"> <li>• Professional Code of Conduct and Regulatory Bylaws established before proclamation</li> <li>• Implementation policies have been approved for professional conduct committee's work borrowing extensively from SRNA and ACP and vetted via PCC and Council. PCC improving consistent application of policies.</li> <li>• Administrative Tribunal Training provided September, 2009 for PCC, DC and Council as well as applicants for appointment to the two committees</li> <li>• PCC has relied extensively on advice from legal counsel; sometimes did not seek advice soon enough. This was a direct result of lack of resources – not wanting to incur legal fees. This situation has been rectified with legal counsel now available for every PCC meeting.</li> <li>• Registration policies set in consultation with Health prior to proclamation were rigorously enforced. Membership was mostly cooperative.</li> <li>• Entry to practice and CME requirements set in consultation with Health prior to proclamation were implemented. There has been concern from rural areas about the EMR training requirements and from Fire Chiefs and a couple of EMS Directors about the ITLS for EMTs but overall the system has adopted the changes without much fuss.</li> <li>• Issues which arose during the year were promptly addressed – eg. Weak link in the regulatory chain across the country vis a vis licensing exams</li> <li>• Lack of resources for appropriate staffing have hampered implementation of regulatory regime. Have recently added staff assistance for PCC and the Education Cttee as well as support staff to enable</li> </ul>

	<p>concentration on professional tasks at Ex Dir level.</p> <ul style="list-style-type: none"> <li>Do not have a research capacity at this time to support best practice/practice improvement efforts or implement evidence based decision making.</li> </ul>
<p><b>11. Confidence in resources and capacity to manage disciplinary processes</b> (especially having a "surge capacity" to support a major hearing process).</p>	<ul style="list-style-type: none"> <li>College ended 2008 with deficit of \$116,000 as a direct result of being unable to charge an appropriate licensing fee. SK Health grant erased this debt</li> <li>SCoP fees for 2010 have been increased provide adequate resources for day to day operation. However, SCoP will have to build "surge" capacity (other than the existing line of credit (\$200,000)) over time. Council has begun this process with initial investments in reserve funds for legal costs and registry replacement.</li> </ul>
<p><b>12. Evidence of ability to deal with aberrant members</b> (eg. drug addictions; blood born pathogens)</p>	<ul style="list-style-type: none"> <li>SCoP PCC has investigated two cases (one drug addiction and one illness affecting performance). In each case the member was persuaded to surrender the license to practice until they could demonstrate successful completion of appropriate treatment programs and continued good performance thereafter.</li> <li>SCoP has no access at present to any treatment programs specific to the profession. We will rely on public programs.</li> </ul>

**Assessment Against Additional Criteria Suggested by ADM Lauren Donnelly, Saskatchewan Health on August 10, 2009**

Health ADM's Criteria for Professional Regulation	Indicators of SCoP Current Status
<p><b>13. Employer Readiness</b></p>	<ul style="list-style-type: none"> <li>The Health ADM advised that more attention needed to be paid to impact on employers</li> <li>Rural EMS response to the EMR training standards, and Fire Chiefs response to fee increases and CME requirements suggest SCoP has some work to do to be cognizant of employer impacts. Council has met with Fire Chiefs, SEMSA Board and SARM Board to discuss issues; invited regular meetings</li> <li>SEMSA has been supportive of the college initiatives this past year</li> </ul>
<p><b>14. System Readiness/System Implications are addressed</b></p>	<ul style="list-style-type: none"> <li>The Health ADM suggested the Ministry had to prepare the system for changes such as scope of practice changes. It is not clear whether this "preparation" is underway.</li> <li>CPSS expressed willingness for SCoP to take responsibility for scope of practice but only when the Ministry of Health indicates approval of such a transition</li> <li>SRNA has expressed concern about the lack of a clear scope of practice for paramedics; there have been some difficulties between nurses and paramedics in Emergency Departments</li> <li>SCoP is not yet "plugged in" to the system networks that would help us assess system readiness</li> <li>SCoP Executive Committee has been meeting regularly with SK Health officials to negotiate a transitional process to involve SCoP in the management of scope of practice/protocol changes.</li> </ul>
<p><b>15. Supported by Human Resource Plan</b></p>	<ul style="list-style-type: none"> <li>A Ten Year Health Human Resource Plan is under development by Saskatchewan Health. SCoP will be consulted in the development of this plan.</li> <li>SCoP has no human resource plan developed for paramedics.</li> </ul>

