Brief to EMS Review Committee

The Saskatchewan College of Paramedics

The Council of the Saskatchewan College of Paramedics welcomes this opportunity to address the EMS Review Committee. The Saskatchewan College of Paramedics (SCoP) is a fledgling regulatory body charged with serving and protecting the public by ensuring the competence and professionalism of emergency medical practitioners or "paramedics" as the public has come to know us.

Self-regulation is the gold standard of professionalism. The creation of the Saskatchewan College of Paramedics signifies the achievement of the highest professional standard for paramedics. The responsibility given to the paramedics in Saskatchewan through self-regulation is considerable. Ours is a mature profession that is equal to that responsibility. The *Paramedics Act* was proclaimed on September 1, 2008, and we have worked diligently since that time to create the organization necessary to license our members and govern their conduct. We have a small office in Regina and a staff of two. We continue to conduct most of the work of the organization through Council and eight committees of volunteers – members who devote considerable time and effort to SCoP functions such as Registration, Education, and Professional Conduct.

Our members worked closely with Saskatchewan Health for nearly a decade to achieve self-regulation. The motivation for our members was principally concerns over competence, professional conduct and continuing medical education in the field. In our first six months as a regulatory body, SCoP has tightened up the license renewal process ensuring that we know who our members are and what skills they have, begun the process of reform of our continuing medical education requirements to emphasize continuing competence, and received and begun to investigate five complaints respecting professional misconduct or incompetence.

SCoP Membership

Saskatchewan paramedics work tirelessly to ensure Saskatchewan people receive the highest standard of emergency medical care. Our profession encompasses several occupational groupings: emergency medical responder (EMR), emergency medical technician (EMT) known in some parts of the country as primary care paramedic (PCP), emergency medical technician – advanced (EMT-A), and emergency medical technician – paramedic (EMT-P) or advanced care paramedic (ACP). Some provinces also have an occupational grouping at the critical care paramedic (CCP) level. We will use the term "paramedic" to refer to all these occupations, with the more specific titles when a particular level is referenced.

We have just come through our first registration cycle as a regulatory body. The attached document (Attachment A) provides a statistical description of our membership. In summary, as of January 31, 2009, SCoP had registered 1735 members with 1283 listing their employment in the Health Sector.

About 60% of our paramedic practitioners are in the EMT occupational group (1028); with 18% at the EMR level (314); 11% EMT-A (206) and 10% EMT-P (187). Recruitment in recent years has focused at the EMT and EMR levels. The Fire and Industrial Sectors employ mainly full time paramedics at the EMT level while Health EMS employs the full range of occupational groups with a ratio of 40:60 full time to part time. EMT-A and EMT-P practitioners are more likely to be employed full time. EMRs are almost all (93%) employed part time.

Approximately one-third of Saskatchewan's paramedics are women (599). This proportion is not uniform throughout all practitioner groupings. EMRs (43% female) and EMT-As (40% female) are disproportionately more likely to be female while EMT-Ps are much more likely to be male (23% female). The women are employed principally by the Health Sector where 42% of the paramedic workforce is female. While the majority of our members are aged between 21 and 40, nearly one-third of EMRs are over 50.

Of those that work in the Health Sector three-quarters are employed outside the 7 largest urban centers. Most EMRs are employed in rural settings. Most EMT-Ps are employed in urban settings. Although urban members are more likely to be employed full time, there is a wide variation in patterns of employment in rural and urban settings. Some Health Regions employ disproportionately more part time paramedics than others. It is not clear why there is such variability across Health Regions.

Preparatory Training and Scopes of Practice

As noted earlier Saskatchewan recognizes four licensing levels for paramedics. There is a significant difference in training requirements for the various levels as can be seen in the following chart. EMT-Ps are required to have a two year diploma while EMRs need only a two week certificate. The training requirements for EMR, EMT and EMT-P all match the competencies outlined for those occupations in the National Occupational Competencies Profile approved by the Paramedics Association of Canada. The EMT-A is a license unique to Saskatchewan and the training was designed to meet the Scope of Practice.

There are significant differences in the scopes of practice of the four occupational groupings in Saskatchewan and across the nation – a fact reflected in the wide variability in training requirements. The Scope of Practice differences can best be understood (looking from EMR to the EMT-P levels) as a continuum from least to most invasive practices and from the use of none to the use of a wide range of medications. However, this continuum is not evenly graduated. There is a much greater difference in scope of practice between the EMT-A and EMT-P levels than one finds between the EMT and EMT-A levels.

Required Training for Entry to Practice at the Four Licensing Levels in Saskatchewan

Practitioner License	Training Requirement	Length of Training
Emergency Medical Responder	Must meet NOCP levels for EMR – example Red Cross EMR training or St. John Ambulance MFR2 training	About 80 hours
Emergency Medical Technician	Primary Care Paramedic in a CMA accredited program	Varies by school – in SK it is 28 weeks
EMT – Advanced	Intermediate Care Paramedic from a CMA accredited school	Not available in many schools. In SK 21 weeks in addition to PCP
EMT - Paramedic	Advanced Care Paramedic from a CMA accredited program	Varies by school – in SK it is 59 weeks in addition to PCP

Continuing Medical Education

The effectiveness of our members on any given day is related directly to their degree of mastery of key competencies which can mean life or death in emergent situations. Continuing Medical Education (CME) is a very significant tool to hone those skills and refresh critical knowledge on an annual basis. It is also a means for ensuring that our members become acquainted with best practices and new technologies as they evolve. For these reasons CME is a critical requirement for eligibility for license renewal as a practicing member.

Council is committed to reform the CME requirements so that the commitment to continuing competency is met and members are more clearly accountable for maintaining their skills and reflecting on how they can improve their practice. The Ministry of Health has been supportive of this direction. The *Regulatory Bylaws Pursuant to the Paramedics Act*, approved by the Minister upon the establishment of the College in 2008, implemented new requirements for CME. Council has built on those changes to set the 2010 CME requirements which can be found on our web site.

Of particular interest to the EMS Review may be the requirements laid out in the bylaws which call for all paramedics at the EMT level to achieve ITLS Basic certification in 2009, EMT-A level to achieve ITLS Advanced certification in 2009 and at the EMT-P level to achieve PALS certification in 2009. In order to be eligible for license renewal for 2010 our members will need to add these certifications to their portfolio of skills if they do not now have them. This will require a significant effort across the province to provide the relevant training to about 1000 practitioners who do not now have these certifications.

Another provision in the *Bylaws* is for all certifications required of members (BLS HCP (C), ITLS, ACLS and PALS) to be achieved within two years of the licensing year. In effect this provision requires that certifications which typically extend for three years, must now be current for the entire licensing year. Some members whose certifications expire in 2010 will need to renew those certifications prior to the end of 2009 in order to be eligible for renewal of their license for 2010.

We raise these examples of how the CME system is changing as they have implications for how EMS organizes and resources services to accomplish continuing competency of practitioners. This needs to be factored into any forward planning for EMS in the province.

Labour Mobility

Premiers have agreed to amend the *Agreement on Internal Trade*, Labour Mobility Chapter, effective January 1, 2009, to establish full labour mobility for all regulated professions by April 1, 2009. Full labour mobility means that every worker certified for an occupation by a regulatory authority shall, upon application, be certified by the receiving province with no further assessment, training or experience requirements.

Paramedic Regulators across Canada have agreed on an approach to implement full labour mobility as required by the First Ministers (see Attachment C). This is a challenging task given the complexity of regulation of Paramedics across the country. There are over 20 different titles in use in the profession with many differences in scope of practice and required occupational competencies. The same title may not mean the same level of competence or scope of practice as one moves from province to province. However, with full labour mobility, practitioners with these titles would have to be licensed by any jurisdiction with the same or similar titles unless a province approved a legitimate objective differentiating a material difference in competence or scope of practice.

The agreed approach anticipates a transition in every province from the current array of some two dozen levels of license and scopes of practice to four occupational groupings: EMR, PCP, ACP and CCP. Building on an initiative begun in 1998, National Occupational Competency Profiles (NOCPs) have been developed for these four occupations, and most provinces have already adopted this regime. In Saskatchewan, although our training requirements correspond to the NOCPs, scope of practice has lagged behind so that our EMR, PCP and ACP practitioners have narrower scopes of practice than their counterparts in other provinces and narrower than the training they have received.

Another implication of the Labour Mobility Agreement is the requirement for Saskatchewan to implement licensing examinations for the four occupational groupings in the paramedic profession. Saskatchewan is currently the only western province (including Ontario) that does not have a licensing examination which must be passed to be eligible for a license to practice in the province. As a consequence, we are experiencing a rash of applications for licenses from

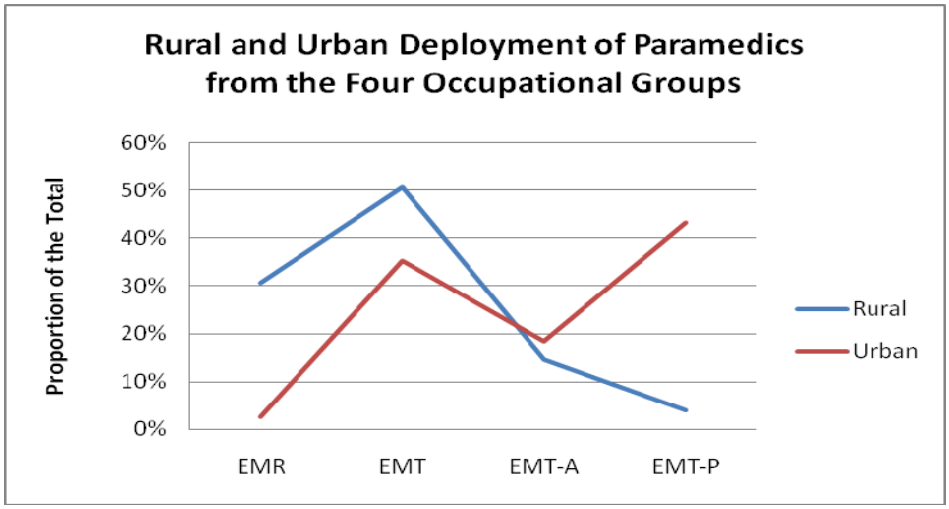
paramedics who are unable to be licensed in their home province, either because they have failed the exam there or have not written it. They obtain a license from Saskatchewan, where they qualify because they have CMA accredited training and there is no exam. However they have no intention of working in our province. As soon as we issue them a Saskatchewan license, they request a "Verification of Good Standing" from us to be sent to their home province which, in compliance with full labour mobility, must now issue them a license. Other jurisdictions are worried about this trend accelerating as students learn how to avoid the exam, and are also worried that Saskatchewan, with its lower standards, will begin to license paramedics from other countries who would not pass their licensing exams, but will be eligible for their license as soon as a Saskatchewan license is issued.

This situation is a grave risk for Saskatchewan. As the weak link in the regulator network, we attract the least qualified, least competent professionals which can only spell trouble for the province and harm to our patients in the long run. And we lose credibility and trust from our counterpart regulators across the country making it more likely that there will be exemptions sought to exclude our practitioners from transferring to their provinces. This could result in more complaints from Saskatchewan professionals who experience less, not more, labour mobility.

SCoP has begun discussions with the Ministry of Health to seek support for the Paramedic Regulators plan and to assess the implications for Saskatchewan.

Issues and Recommendations

<u>The critical issue for Saskatchewan Emergency Medical Services is the huge inequity in available pre-hospital emergency medical care across Saskatchewan.</u>



The research is clear: the earlier treatment is available for major trauma or cardiac arrest, the higher the likelihood of survival without injurious effects. Yet in Saskatchewan the further away you are from an acute care hospital, the LESS likely you are to encounter care by an advanced

care paramedic. The longer the distance you must travel to receive emergency care, the LESS likely you are to have a care-giver in the ambulance who can administer medication and treatment that can increase your likelihood of survival without deleterious effects.

Ask any paramedic where they would rather be if they were to suffer cardiac arrest or severe trauma. Here's a sample of the response you'll hear:

> *Definitely I would want to be in a city. Rural EMS providers don't have the skills to effectively manage these situations. An ambulance may not have an ICP on board, much less an ACP and there are no ACP rovers around. It's also proximity to hospital but that would be less important if there were ACP's in rural SK. (A rural EMT-A)*

Since many health facilities in rural Saskatchewan have closed their emergency doors, the average length of time from Time of Alert to Time of Arrived Destination (or ER) is 1.5 hours for rural EMS. **The province needs a higher level of competence amongst rural paramedics to ensure that appropriate care can be given**.

The pattern of deployment of paramedics across the province demonstrates the challenge of ensuring comparable levels of service across a geographically diverse province. There are many reasons for the dearth of advanced care paramedics in rural Saskatchewan:

- Ministry of Health restrictions on where advanced care services can be implemented and no Ministry requirement for minimum staffing standards
- Funding on the basis of a per call rather than service availability formula
- Recruitment and Retention Issues, such as:
    - Lack of volume of calls and, therefore, lack of opportunity to practice advanced skills
    - Lack of full time employment (for example this makes Fire a more attractive employment sector than EMS, and it makes urban EMS more attractive than rural)
    - Lack of opportunities to refresh knowledge and skills and learn leading edge practices
    - Lack of a collegial environment which comes from working amongst peers
    - The time it takes away from home and employment to train to be an ACP discourages people who are committed to living in rural areas from advancing
    - Quality of Life – some rural practitioners are on call 24 hours a day

Although we do not have the expertise to speak to all of these issues, there are a few which we believe could be addressed to the benefit of patients and the health care system as a whole.

We recommend that the EMS Review Committee incorporate the following recommendations into its final report:

1. **Broaden opportunities for paramedics to practice advanced skills**
2. **Establish and enforce minimum standards for EMS staffing and responsiveness across the province**

3. **Address the lag in scope of practice at the EMR and EMT/PCP levels to ensure adequate care is available in rural SK**
4. **Ensure competency of EMS personnel**

We will address each of these recommendations with specific ideas of how they might be accomplished.

Recommendation 1: Broaden opportunities for paramedics to practice advanced skills

1.1 *Facility based practice.* Many of the recruitment and retention issues could be addressed by rethinking the role of the paramedic in the health care system. For example, paramedics skilled in patient assessment, intubation and treatment of trauma are very effective in emergency rooms, operating rooms, critical care units and community health clinics and outposts. It may be that by broadening opportunities to practice their advanced skills in rural Saskatchewan in facility, as well as ambulance settings, health regions could attract and retain more advanced care paramedics. More efficient and effective use of advanced care paramedics can do much to facilitate integration of EMS into the provincial health system as it will give a wider range of professions the opportunity to work in teams with paramedics.

1.2 Create a New Critical Care Paramedic level. There are examples of such practices already occurring in Saskatchewan. They tend to be in our biggest urban centers where the expertise of advanced care paramedics has been deployed in ERs and CCUs. The Critical Care Paramedic designation and scope of practice are used in other provinces to license these paramedics who, under direct supervision of physicians, are enabled to use many more medications and procedures. The College is considering a license at the CCP level.

Recommendation 2: Establish and enforce minimum standards for EMS staffing and responsiveness

2.1 Make EMT/PCP trained the minimum standard for the back of an ambulance. The discrepancy between rural and urban services in availability of advanced care can be lessened by establishing minimum standards for EMS. Some years ago Saskatchewan Health recommended the minimum standard of an EMT in every ambulance. Rural Saskatchewan has made uneven progress in implementing this standard. An EMR has two weeks of training. An EMT/PCP has 28 weeks of training. There are many more procedures and some medications available in the EMT/PCP scope of practice that could make a significant difference in survivability for acute and emergent cases. First Responders and EMRs need to be thought of as people who augment the system, not as replacements for essential care.

2.2 Research best practice in deployment of a mix of practitioner levels. As indicated earlier, there is significant and unexplainable differentiation in deployment of practitioners across the Health Regions. It is likely that there is a narrower range of deployment which represents best practice for the most effective and efficient outcomes for patients and Health Regions.

Research should be undertaken to discover this best practice range and promote it to the Health Regions.

2.3 Ensure services are large enough and sufficiently resourced to offer full time employment to a majority of their practitioners. The practitioner's level of competence and commitment to keeping current is affected by employment status. Full time employment supports a more professional work force both because practitioners are more likely to view themselves as professionals and because full time staff are more likely to access CME centred on current and best practices. Recruitment and retention of more highly skilled staff is directly related to the ability to offer full time employment.

2.4 Establish minimum response times for emergent and urgent calls. EMS across the province should be responsible for ensuring a response time of no more than 30 minutes for urgent and emergent calls regardless of location. This implies the need to resource the system to have strategically placed ALS (not intermediate care but advanced care paramedics) in rural services including clinics and rural emergency rooms. Placing EMS services strategically may also mean incorporating the very small services with very few calls into larger, better equipped services with more highly trained staff. This may be combined with an organized (perhaps scheduled) well-equipped, well-trained first responder system (that could include paramedics) in outlying communities around the base. A by-product of such an approach could be an improved quality of life for rural EMS staff by standardizing staffing compliments and providing support to enable larger services to reduce or eliminate 24-hour shifts thus improving recruitment and retention.

2.5 Improve efficiencies in transport to enable improved responsiveness. To the extent that an ambulance and crew are on the road to transport transferring patients, they are not available for the emergent call in the home area. Improved efficiencies in transport can enable improved local responsiveness. This can be accomplished in a number of ways. For example:

2.5.1 Eliminate long delays in the off-loading of patients at emergency departments. These delays, especially in rural Saskatchewan, prevent crews from returning to their service area in a timely fashion. This causes other services to have to cover larger regions and increases response times.

2.5.2 Consider scheduled multi-patient units for non-emergent transports. There are efficiencies to be gained by coordinating non-emergent transports on a regional level in both urban and rural areas using multi-patient units, much like a bus system, albeit with a more flexible route coordinated by dispatch centers.

2.5.3 Make better use of empty returning ambulances to do patient return transfers. This requires a more coordinated dispatch and perhaps some scheduling of patient transfers.

2.5.4 Enable a Treat and Release Protocol. Not everyone needs to be taken to a hospital. Responsiveness could be further improved throughout the province by allowing for a Treat and Release protocol. Of course, the province would first need to ensure that health insurance agencies recognize this as a benefit to their subscribers.

Recommendation 3: Preserve and increase Scope of Practice in rural Saskatchewan

3.1 Align practice with the NOCPs by increasing the Scope of Practice for EMT/PCP trained and phasing out the EMT-A level. The biggest challenge for Saskatchewan to align with the NOCPs is the EMT-A level. Currently Saskatchewan and Nova Scotia are the only provinces with an Emergency Medical Technician – Advanced/Intermediate Care Paramedic license level, and Nova Scotia has already decided to phase it out in favour of the four levels of the NOCPs. Saskatchewan should also phase out this level.

The EMT-A was never intended as a step toward the EMT-P. Rather it was originally created in Saskatchewan to provide rural areas, where recruitment of EMT-Ps was very difficult, with an advanced skills set including how to prioritize care for critically ill patients, as well as intravenous, airway control and some symptom relief skills. Many of these skills are now included in the scope of practice at the PCP level in other provinces and are being incorporated into the revised NOCPs (which are being reviewed with regulators and are likely to be approved in 2009).

Likely the best solution to phase out the EMT-A level is to raise the PCP scope of practice to the EMT-A level (which is the new NOCP standard plus a few medications) thus making the EMT-A level redundant. This would also raise the skill level for the majority of paramedics throughout the province with a significant improvement for rural Saskatchewan. This would require Health, the College and SIAST to work together to create a bridging program from the current PCP training to the new standards and make it available throughout Saskatchewan for about 1000 practitioners.

3.2 *Increase EMR Scope of Practice and require all EMRs to upgrade to the new level.* When the Government of Saskatchewan established SCoP, it approved *Regulatory Bylaws* which required an increase in the training necessary for eligibility for an EMR license. Although Health thus increased the qualifications for EMRs, it has made no change in the EMR scope of practice. Saskatchewan's EMRs have one of the narrowest scopes of practice in the country. Just raising the bar to the national occupational competencies for EMRs would improve the care available throughout the province. Of course, this would mean that the existing 316 EMRs would need to upgrade their skills. This is manageable over a period of years as the approved training programs are two weeks in length, and anyone with First Responder training has already completed the first week.

3.3 Better Integrate EMS in the Health Care System. In addition to the facility-based practice suggested earlier, this would require the integration of private ambulance services into the mainstream health system. EMS staff should be viewed as part of the team no matter who the

employer. Health Regions need to ensure inclusion of private EMS in their communication network and involve their staff in the health region's teams, training and quality assurance processes.

Recommendation 4: Ensure competency of EMS practitioners

A key goal of the College for all paramedics throughout the province is current competence reflective of scope of practice and current best practices in the field of paramedicine. Access to new knowledge and skills is critical to ensure the best possible care is available no matter where the paramedic works.

4.1 *Implement Licensing Exams.* Licensing exams will ensure that our practitioners have the minimum knowledge and skills required to perform the competencies that are part of the scope of practice for their license. The College is actively exploring the possibility of a National or Western licensing examination to assist in rapid implementation of this requirement at an affordable cost.

4.2 Make online learning accessible for paramedics. But what should be done to ensure that that level of competence is maintained and even increased over time? Three-quarters of the paramedics in Saskatchewan work in rural and northern parts of the province, at some distance from SIAST campuses. Most ambulance services offer a continuing medical education (CME) program that meets minimum recertification requirements. But there are limits to what can be done by a small service far from the expertise of the urban centers.

Other jurisdictions have initiated distance education programs for paramedics. These online programs are accessible even at northern mine sites and can assist services to broaden the range of topics available for CME. SCoP has reviewed a few of the available online programs. Although we are unlikely ever to be able to afford to mount our own online programming, these sites provide relevant, quality learning opportunities for an affordable fee. EMS should be encouraged to incorporate some online learning into the annual cycle of CME opportunities. A lower cost per student can be achieved through a provincial agreement with some of these online companies. EMS managers should consider a coordinated approach. The College would be pleased to work with EMS to facilitate such an effort.

4.3 Provide a mobile simulator for paramedic training, testing and refresher. Online learning and lectures cannot replace the need for practical experience in using skills. Particularly for rural services which do not have a high volume of calls, practitioners can become rusty in key life-saving skills just from lack of practice. MD Ambulance has had great success in using a Simulator to give paramedics additional practice in these key skills. A mobile lab with a simulator could provide much needed training and practice in rural and northern Saskatchewan. It could also be very helpful in assessing the skills of new applicants for licenses if it were to become part of a provincial licensing examination process through the College.

4.4 Provide support for small operators to train their staff. Rural EMS, in particular, has much less exposure to call volumes of larger centers and staff can get "out of practice". This can be somewhat offset by continuing medical education (CME). However, lack of trainers and lack of access to new information can cause training programs to be stale and ineffective.

Capacity to provide adequate continuing medical education for staff is directly related to the size of the EMS operation. It takes a bigger proportion of the small operator's budget to provide the same quality of training for their staff as one might find in a larger service. Given the importance of competence to the effective practice of paramedics, the College recommends that consideration be given to support training the staff of the smaller operators.

4.5 Provide assistance and incentives for rural EMT/PCPs to train to the ACP level. In Saskatchewan ACP training is only offered in one location (Regina) and in one modality (classroom instruction). Many people do not want to take 15 months of unpaid time away from home in order to train to be an advanced care paramedic. Incentives might include bursaries or paid leave for rural EMTs to train to the ACP level providing they return to practice in rural Saskatchewan. A distance education approach for the didactic portion of the program is also recommended so that practitioners do not have to take so much time away from home. SIAST may need to be prompted and resourced to make this available in a timely manner.

4.6 Implement systematic EMS call reviews for quality assurance purposes in all Health Regions using a uniform methodology. Paramedic practice should be subject to critique so that practitioners become aware of poor practices and learn best practices. Cross service involvement or rural/urban engagement in quality assurance reviews could also assist those from lower volume services to have a higher quality learning experience from the process.

Conclusion

The Council of the SCoP appreciates the opportunity to share our ideas with the EMS Review Committee. Our suggestions can be summarized in four recommendations:

1. Broaden opportunities for paramedics to practice advanced skills
2. Establish and enforce minimum standards for EMS staffing and responsiveness across the province
3. Address the lag in scope of practice at the EMR and EMT/PCP levels to ensure adequate care is available in rural Saskatchewan
4. Ensure competency of EMS personnel.

The Council would be pleased to respond to questions the Committee may have arising from this brief.

Attachment A

SASKATCHEWAN COLLEGE OF PARAMEDICS

Saskatchewan Paramedics -- A Profession to be Proud of!

Saskatchewan paramedics work tirelessly to ensure Saskatchewan people receive the highest standard of emergency medical care. Our profession encompasses several occupational groupings: emergency medical responders (EMR), emergency medical technicians (EMT) known in some parts of the country as primary care paramedics (PCP), emergency medical technician – advanced (EMT-A), and emergency medical technician – paramedics (EMT-P) or advanced care paramedics (ACP). Some provinces also have an occupational grouping at the critical care paramedic (CCP) level. We will use the term "paramedic" to refer to all these occupations, with the more specific titles when a particular level is referenced.

Table 1: Paramedics Employment Status by Sector (January 31, 2009)

Sector and Employment Status	EMR	EMT	EMT-A	EMT-P	Total
Health	**305**	**601**	**201**	**176**	**1283**
Full Time	21	224	133	145	523
OTFT	284	377	68	31	760
Fire	**5**	**324**	**1**	**4**	**334**
Full Time		307	1	4	312
OTFT	5	17			22
Industrial	**2**	**56**	**2**	**2**	**62**
Full Time	1	45	2	2	50
OTFT	1	11			12
Other	**2**	**47**	**2**	**5**	**56**
Full Time		9	2	3	14
OTFT	2	38		2	42
Total	**314**	**1028**	**206**	**187**	**1735**

Table 1 shows what sectors employ paramedics in Saskatchewan and the employment status (full time or other than full time) by occupational grouping. There were 1735 paramedics registered with the Saskatchewan College of Paramedics on January 31, 2009. The majority work in the Health Sector

(1283) principally in Emergency Medical Services throughout the province. About 20% (334) of the paramedics work as fire fighters. Industrial medics account for nearly 4% (62).

About 60% of our paramedic practitioners are in the EMT occupational group (1028); with 18% at the EMR level (314); 11% EMT-A (206) and 10% EMT-P (187). The Fire and Industrial Sectors employ mainly full time paramedics at the EMT level while Health EMS employs the full range of occupational groups with a ratio of 40:60 full time to part time. EMT-A and EMT-P practitioners are more likely to be employed full time. EMRs are almost all (93%) employed part time.

Approximately one-third of Saskatchewan's paramedics are women (599). This proportion is not uniform throughout all practitioner groupings. EMRs (43% female) and EMT-As (40% female) are disproportionately more likely to be female while EMT-Ps are much more likely to be male (23% female). The women are employed principally by the Health Sector where 42% of the paramedic workforce is female (see Table 2).

Table 2: Practitioner Gender by Sector

Sector	Female	Male	Total
Health	550	733	1283
Fire	14	320	334
Industrial	16	46	62
Other	19	37	56
Total	**599**	**1136**	**1735**

Paramedics in the Health Sector

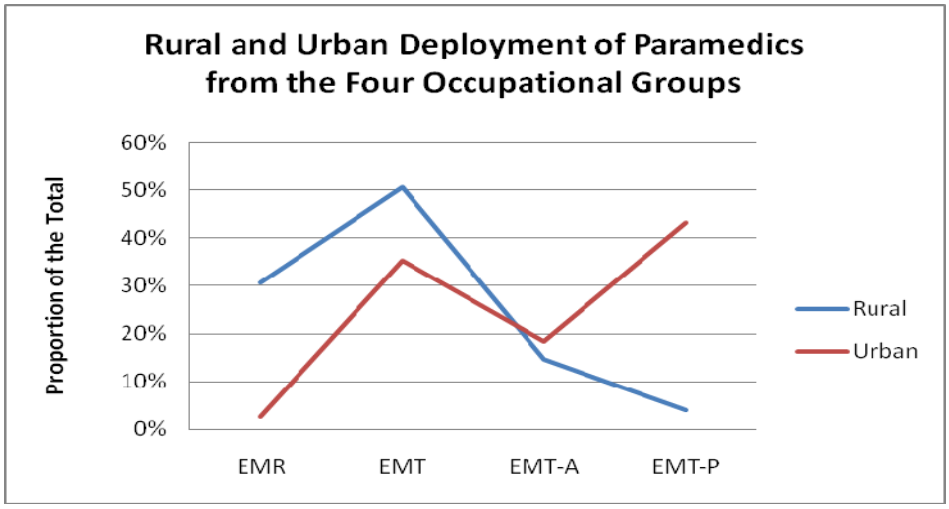
Looking more closely at the Health Sector (Table 3), there are 1283 paramedics registered with SCoP who list the Health Sector as their main employment.

Geographic Distribution. There is a distinctly different pattern of deployment across the occupational groups in rural areas compared to the larger cities in Saskatchewan. One-quarter of the paramedics working in the Health Sector are deployed in urban areas (where urban is defined as the Saskatoon, Regina, Prince Albert, Moose Jaw, Swift Current, Yorkton and North Battleford Emergency Medical Services). Graph 1 shows the proportion of each occupational group employed in rural and urban areas. It contrasts the very high use of EMRs and low use of EMT-Ps in rural Saskatchewan, with the opposite pattern (higher EMT-Ps and very low EMR use) in the urban centers.

Table 3: Distribution of Practitioners Rural vs Urban within Health Regions

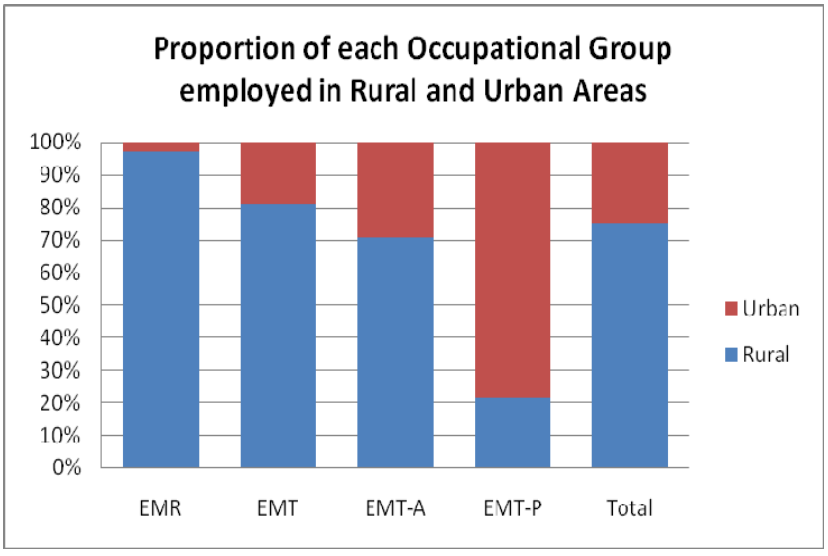
Health Regions	EMR	EMT	EMT-A	EMT-P	Total
RURAL					
Athabaska		1	3		4
Cypress	42	29	3	1	75
Five Hills	8	23	1	1	33
Heartland	84	60	24	1	169
Keewatin Yatthe	13	12	3		28
Kelsey Trail	11	36	14	10	71
Mamawetin Churchill	7	11	3	2	23
Parkland	3	16	3	4	26
Prairie North	21	54	16	4	95
Regina Qu'Appelle	13	61	28	4	106
Saskatoon	21	60	17	5	103
Sun Country	60	78	15	3	156
Sunrise	13	47	12	3	75
Total Rural	**296**	**488**	**142**	**38**	**964**
URBAN					
Cypress - Swift Current	7	10	4	1	22
Five Hills - Moose Jaw		13	2	10	25
Parkland - Prince Albert		20	8	13	41
Prairie N - N Battleford	1	12	1	8	22
RQ - Regina	1	27	5	55	88
Saskatoon - Saskatoon		24	29	51	104
Sunrise - Yorkton		7	10		17
Total Urban	**9**	**113**	**59**	**138**	**319**
Grand Total	**305**	**601**	**201**	**176**	**1283**

Graph 1



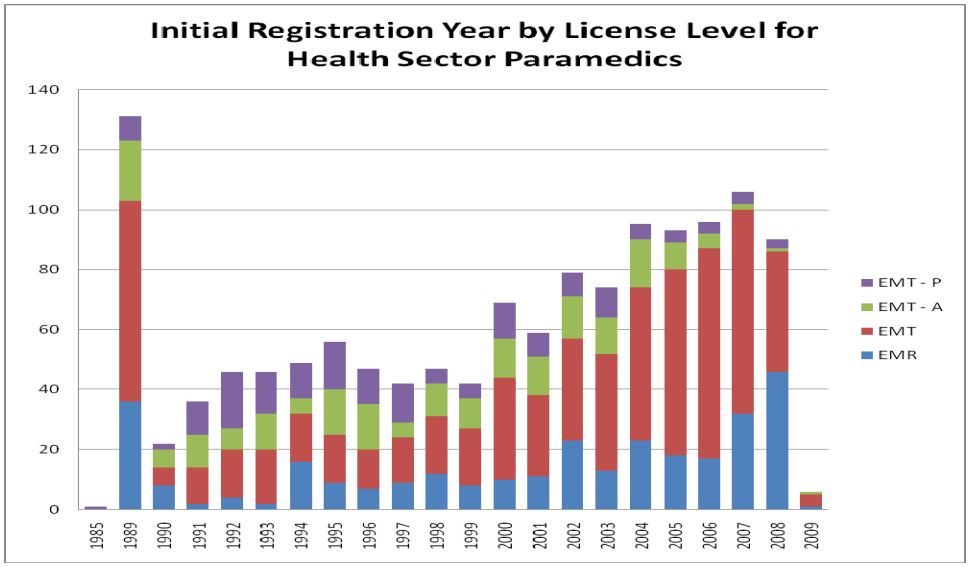
Another way to look at this is the proportion of each occupational group which works in urban and rural areas. This is shown in Graph 2 below. EMRs are a rural occupation group with very few exceptions (only 9 EMRs work in urban centers). EMT and EMT-As are more likely to be working in rural areas while EMT-Ps are predominantly an urban workforce.

Graph 2



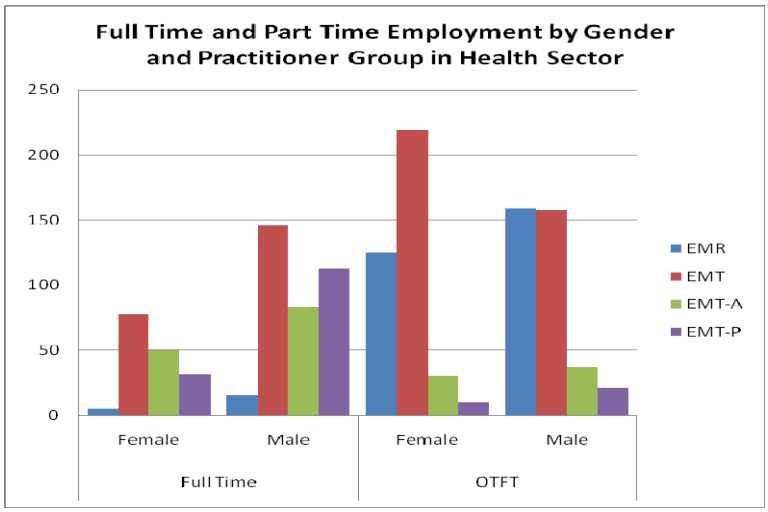
Recruitment Trends. The year of initial registration shown in Graph 3 indicates the practitioners joining the work force in Saskatchewan each year. Recruitment trends do not indicate a change in the deployment patterns. In the past five years the majority of recruitment has been at the EMR and EMT levels.

Graph 3



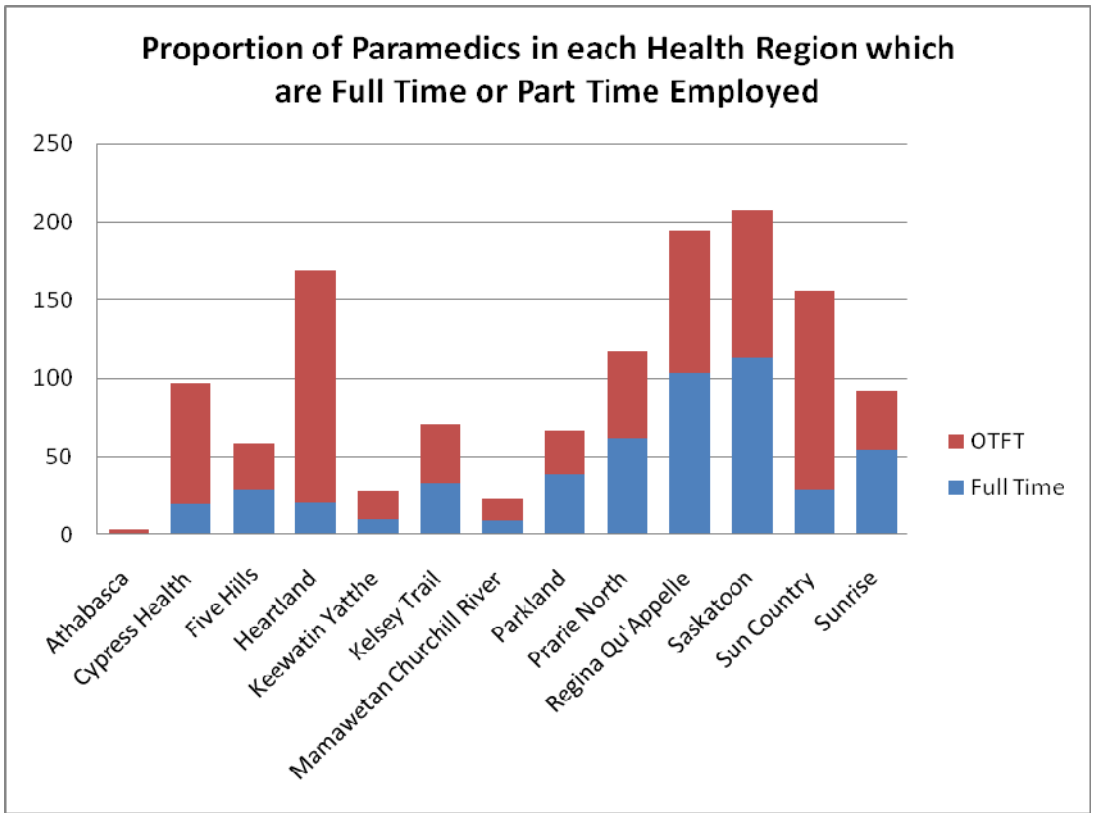
Employment Status. A gender analysis of Health Sector paramedics (Graph 4) shows the occupational group trumps gender at the EMR level – both women and men are most likely to be employed part time if they work as an EMR. This is not the case in the other occupational groupings. Women are more likely to be employed part time at all levels and especially at the EMT level, while full time employment at the EMT, EMT-A and EMT-P levels is more likely for men.

Graph 4



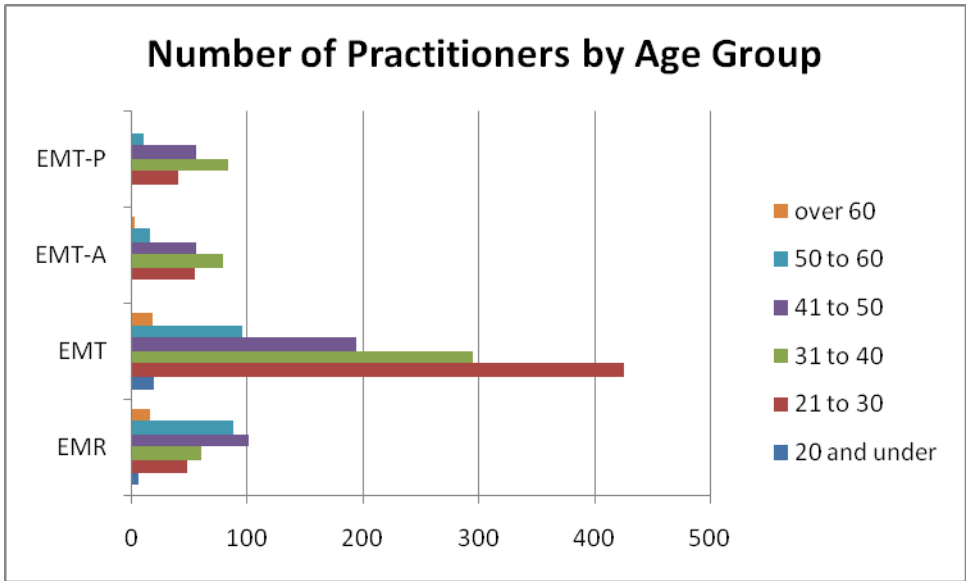
Employment Status is more affected by the Health Region than the occupational grouping as shown in Graph 5. Some Health Regions employ disproportionately more part time paramedics than others. It is not clear why there is such variability across Health Regions.

Graph 5

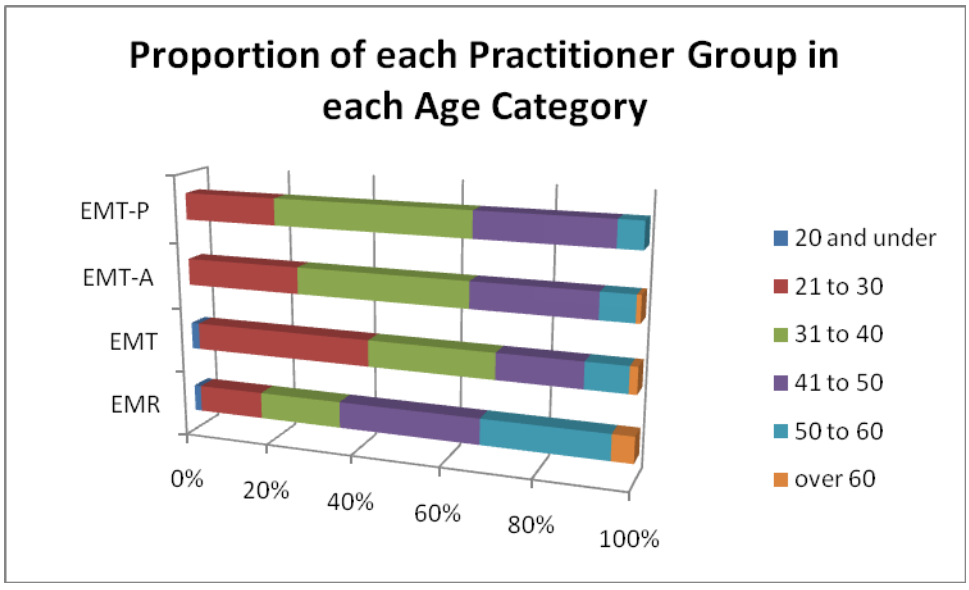


Age. As can be seen in Graph 6, the majority of EMTs are under 40 years of age while most EMRs are over 40. EMT-As and EMT-Ps are more likely to be over 40. From a work force planning perspective, the highest number of people closing in on retirement age are at the EMR and EMT levels. In fact, nearly 40% of EMRs are over 50 as can be seen in Graph 7.

Graph 6



Graph 7



Fire Sector

Looking specifically at the Fire Sector, there are 354 paramedics with all but 10 of them being EMTs. As shown in Table 4 below, most paramedics in the Fire Sector work full time (94%) and most are men (96%).

Table 4: Gender and Employment Status by License Level in the Fire Sector

	EMR	EMT	EMT-A	EMT-P	Total
Female		**14**			**14**
Full Time		8			8
OTFT		6			6
Male	**5**	**330**	**1**	**4**	**340**
Full Time		319	1	4	324
OTFT	5	11			16
Total	**5**	**344**	**1**	**4**	**354**

The Saskatoon and Regina Fire Departments employ the only EMT-Ps in the Fire Sector while 17 Wing Dundurn has the only EMT-A. The R.M. of Frontier and the Weyburn Fire Department are the only employers in the Fire Sector who have registered EMRs. (See Table 5). Two thirds of the paramedics in the Fire Sector work in Saskatoon and Regina with 44% in Saskatoon. Eight of Saskatchewan's 12 cities have registered paramedics on staff.

Table 5: Practitioner Level by Fire Sector Employer

	EMR	EMT	EMT- A	EMT-P	Total
DND 17 Wing Dundurn		**20**	**1**		**21**
Saskatoon Fire & Protective Services		**154**		**3**	**157**
Dalmeny Fire & Rescue		**7**			**7**
Humboldt Fire Dept.		**1**			**1**
Martensville Fire Dept.		**2**			**2**
Moose Jaw Fire Department		**26**			**26**
North Battleford Fire and EMS		**2**			**2**
Prince Albert Fire & Emerg. Services		**27**			**27**
R.M. Of Frontier #19	**4**	**4**			**8**
Regina Fire Department		**82**		**1**	**83**
Swift Current Fire Department		**17**			**17**
Warman Fire and First Responders		**1**			**1**
Weyburn Fire Dept.	**1**	**1**			**2**
Total	**5**	**344**	**1**	**4**	**354**

The majority of paramedics in the Fire Sector are under 30 years of age with only 17 (5%) age 50 and over. See Table 6 for a breakdown of age by license level in the Fire Sector.

Graph 8

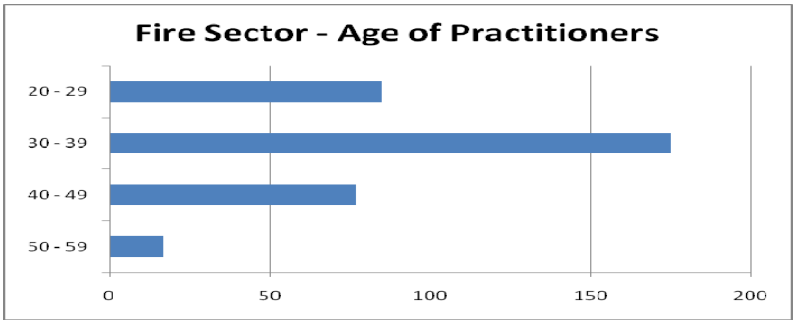
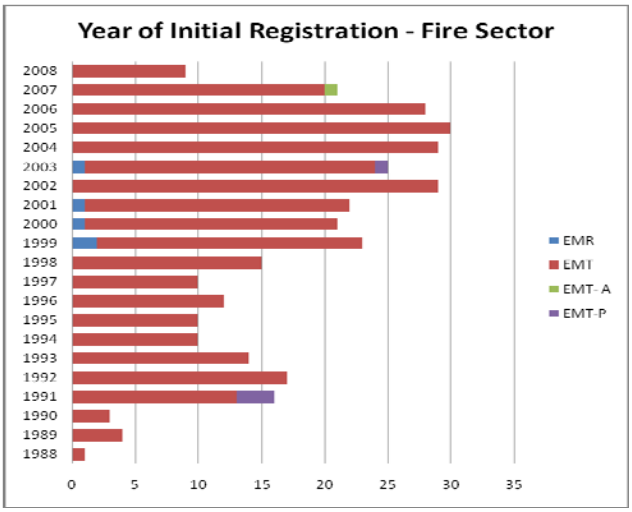


Table 6: Age by License Level in the Fire Sector

Count of Title	Column Labels				
Row Labels	EMR	EMT	EMT-A	EMT-P	Total
50 - 59	3	14			17
40 - 49	1	73		3	77
30 - 39		174		1	175
20 - 29	1	83	1		85
Total	5	344	1	4	354

As Graph 9 demonstrates, recruitment of paramedics into the Fire Sector has been active for the past decade with 20 to 30 new recruits each year. However, this trend was significantly curtailed in 2008.

Graph 9



A key aspect of emergency preparedness in any region will be the number of paramedics available. As can be seen in Table 7, not every Health Region can count on additional paramedics in the Fire Sector. Where Saskatoon has an abundance of fire paramedics, for example, Sunrise, Kelsey Trail, and Heartland have none.

Table 7: Paramedics in the Fire Sector by Health Region

	EMR	EMT	EMT-A	EMT-P	Total
Cypress Health Region	**4**	**21**			**25**
Swift Current Fire Department		17			17
R.M. of Frontier #19	4	4			8
Five Hills		**26**			**26**
Moose Jaw Fire Department		26			26
Parkland Health Region		**27**			**27**
Prince Albert Fire & Emerg. Services		27			27
Prarie North Health Region		**2**			**2**
North Battleford Fire and EMS		2			2
Regina Qu'Appelle Health Region		**82**		**1**	**83**
Regina Fire Department		82		1	83
Saskatoon Health Region		**185**	**1**	**3**	**189**
Martensville Fire Dept.		2			2
Warman Fire and First Responders		1			1
Humboldt Fire Dept.		1			1
Saskatoon Fire & Protective Services		154		3	157
Dalmeny Fire & Rescue		7			7
DND 17 Wing Dundurn		20	1		21
Sun Country Health Region	**1**	**1**			**2**
Weyburn Fire Dept.	1	1			2
Total	**5**	**344**	**1**	**4**	**354**

Attachment C

CANADIAN PARAMEDIC REGULATORS WORKING GROUP

Communiqué #1
January 9, 2009

Meeting of Paramedic Regulators from Across Canada
December 2 and 3, 2008 in Toronto

Executive Summary

Paramedic Regulators from every province except Quebec met in Toronto December 2 and 3, 2008, to consider how to meet the requirements of the amended provincial-territorial agreement on Labour Mobility under the *Agreement on Internal Trade* (AIT). Regulators have identified what it will take to bring jurisdictions into compliance with full labour mobility. The regulators developed an ambitious action plan to achieve basic compliance on an interim basis by mid 2009 and to build the necessary cross-jurisdictional mechanisms to sustain full labour mobility over the longer term.

The regulators believe that full labour mobility can best be achieved by recognizing four distinct occupational groups within Paramedicine. This approach will incorporate work that began in 1998 to define national occupational competency profiles. Significant adjustments will be required within some provinces to transition to a regulatory approach that corresponds to these groups.

Although the AIT does not mandate common provincial standards, regulators are committed to working collaboratively over time to develop more common ground and to promote the notion of "Paramedics without borders".

What is changing in Labour Mobility?

Premiers have agreed to amend the *Agreement on Internal Trade*, Labour Mobility Chapter, effective January 1, 2009, to establish full labour mobility for all regulated professions by April 1, 2009. Full labour mobility means that every worker certified for an occupation by a regulatory authority shall, upon application, be certified by the receiving province with no further assessment, training or experience requirements. The only exceptions will be those established by the provincial government as "legitimate objectives" based on material differences in occupational standards and/or scope of practice. A difference in certification requirements is not, by itself, sufficient to justify additional requirements.

Currently some Paramedic Regulators use licensing examinations or practical skills assessment to determine a practitioner's competence to be licensed when s/he transfers from another

jurisdiction. Other regulators assess whether a practitioner received Canadian Medical Association accredited training as a means to determine competence. Under full labour mobility these practices cannot continue except for unique provincial requirements protected by a legitimate objective approved by the province. If the practitioner is licensed in one province, s/he will be licensed by the receiving province regardless of any differences in standards.

What is the current labour mobility situation for Paramedics?

The Paramedic Regulators from across Canada came together in December, 2008 to determine how best to meet the April, 2009 deadline for full labour mobility. This is a challenging task given the complexity of regulation of Paramedics across the country. There are over 20 different titles in use in the profession, with many differences in scope of practice and required occupational competencies.

In recent years the Paramedics Association of Canada (PAC) has brought together stakeholders to develop a set of National Occupational Competency Profiles (NOCP) for four levels of paramedic practice: Emergency Medical Responder (EMR), Primary Care Paramedic (PCP), Advanced Care Paramedic (ACP) and Critical Care Paramedic (CCP). The NOCPs are currently being updated and PAC has agreed to a significant role for regulators in finalizing the competencies and the formats for their presentation and use.

Some Paramedic Regulators have begun to reference the NOCP titles in establishing registration and licensing levels but have not always adopted all the NOCP competency standards, nor does scope of practice consistently reflect those standards. As a consequence, the same title may not mean the same level of competence or scope of practice as one moves from province to province. However, with full labour mobility, practitioners with these titles would have to be licensed by any jurisdiction with the same or similar titles unless a province approved a legitimate objective differentiating a material difference in competence or scope of practice.

It was clear, however, at the December meeting that, while regulators may have local differences in the “working titles” of Paramedics, many of these classifications have already been mapped to the four NOCP levels, or a transition plan has been mapped out and is being implemented. Furthermore, regulation is undertaken either by government ministries or professional self-regulation, depending on the jurisdiction, and there are many differences in regulatory requirements and processes for licensing or registering practitioners. There has not been a functional network of all these regulators.

What will Paramedic Regulators do to achieve full labour mobility?

The Paramedic Regulators agreed to a short term approach to provide comparability across jurisdictions to enable licensing of transferring practitioners at the most appropriate level, and to a longer term approach to ensure full labour mobility on a sustainable basis.

Short Term

The Paramedic Regulators agreed to establish an interim arrangement for compliance with the AIT full labour mobility provisions. Regulators agreed to identify and define the range of paramedic practice across the country into four occupational groupings based initially on the NOCPs, as a starting point. The regulators agreed that an updated occupational competency profile would be developed for each of these four occupational groups which provides an outline of the scope of practice for each level. Each regulator would then identify the occupational group for which each of its licensure levels were fully compliant. This would create a matrix or "cross walk" that could be used across the country on an interim basis to establish the license level warranted for in-coming workers.

Longer Term

However, given differences in scope of practice, occupational standards, assessment and licensure requirements across jurisdictions, the Paramedic Regulators recognized that the matrix was not sustainable and would be insufficient over the medium and long term to ensure full labour mobility for the occupation. A more robust transition plan will be required.

The regulators recognized that each province would need to consider how to:

- phase out levels of practice that did not conform to the four occupational groups so that all jurisdictions are working with the same four levels of professional practice; and
- bring training programs into alignment with the revised NOCPs for the four occupational groups.

The regulators also agreed to collaborate to:

- work toward a common assessment for internationally trained Paramedics;
- collaborate to develop an assessment toolkit which could be used across jurisdictions to assess competence in each of the four occupational groups;
- incorporate best practices in regulatory processes; and
- track the evolution of professional practice and identify regulatory implications.

How will this be accomplished?

In order to accomplish these objectives and support their continued viability, regulators determined that a formal mechanism needs to be established for collaboration of Paramedic Regulators which would oversee the agreed work, share best practices, develop a national process for continuous improvement of regulatory practices, and develop a process for managing the evolution of the profession to facilitate continued labour mobility over time.

This Paramedic Regulators collaborative would seek financial assistance to support the initiatives identified. An Interim Steering Committee, with three subcommittees, was established to further develop action plans and coordinate the work:

- a Funding subcommittee will develop the project proposal and seek funding;
- a Communications subcommittee will develop products and strategies to assist regulators to explain our objectives and activities to key stakeholders; and
- an AIT Compliance subcommittee will develop the matrix and determine the work needed for transition.

The Interim Steering Committee and subcommittees have scheduled meetings for the next two months. A follow up meeting of all Paramedic Regulators is tentatively planned for February 2009, to finalize interim arrangements and begin work on the longer term.

In addition, the Paramedic Regulators will seek approval for this plan through their separate governance processes.