Environmental Scan and Strategic Planning Paper

Strategic Planning Session
August 31 – September 1, 2009

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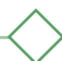

Project Overview and Objectives

The Saskatchewan College of Paramedics (SCoP) retained D.C. Strategic Management Ltd. to provide an environmental scan and planning paper to be used by the College as a foundation for their strategic planning session to be held on August 31 and September 1, 2009. The objectives of the project are to:

- provide an overview of the trends and emerging issues and innovation in the practice of paramedicine and service delivery;
- provide an overview of the practical aspects of and best practices for governance and self-regulation;
- provide an assessment of SCoP's current state as it relates to the best practices of self-governance and self-regulation;
- complete a strategic planning paper for the Council to be provided in advance of the strategic planning session; and
- present the consultants' findings at the strategic planning session.

Project Methodology

The project involved the following steps.

- Twelve detailed interviews (involving 13 individuals) were conducted with representatives internal to the SCoP organization and external stakeholders. A list of interviewees is attached as Appendix A.
- Practice literature provided through the interviews with the practice experts was reviewed by the project consultants.
- Best practices literature on self-governance and self-regulation was identified and reviewed.
- Documents provided by SCoP Executive Director were reviewed. Sources for the practice literature, the governance literature and documents reviewed are listed in Appendix B.
- The final paper and presentation were prepared based on the findings from the literature review, the document review and the interviews.

The literature review is not exhaustive and was limited by the time available for the project, but is sufficient, when combined with the interviews, to provide an overview of directions and issues for the Council to consider and deliberate. Confidentiality of individuals participating in the interviews was assured and results will be reported thematically and will not be attributed to individuals.

Although separate interview guides were prepared for the practice interviews and the governance interviews, some of the questions were similar. Answers and commentary from the interviewees were not always restricted to the main purpose of the interview and information pertinent to another objective of the project was provided. All commentary has been captured and organized into theme areas.

Operating Context

Information was provided to the project consultants to set the context for the paper.

College Development and Accomplishments

The SCoP is a very new organization formed in September of 2008 when it received the formal responsibility for the regulation of the practice of paramedicine in Saskatchewan. Previously, regulation of the profession was performed by the Ministry of Health, and the professional group had been an association of practitioners.

As of July 31, 2009, the College has 1,935 members. Approximately 60 percent of the members are Emergency Medical Technicians (EMTs); 18 percent are Emergency Medical Responders (EMRs); the remaining 22 percent are split evenly between Emergency Medical Technicians – Advanced (EMT-A) and Emergency Medical Technicians – Paramedics (EMT-P). The membership is two to one, male to female. It is a fairly young profession with the majority of the members (particularly EMTs) under the age of 30 and very few members over the age of 50. All of the Council members are either EMT-Ps or EMT-As.

In the short time since receiving the responsibility to regulate the profession, the College has accomplished a great deal. It has:

- hired an Executive Director/Registrar and established an office;
- ensured all the Committees of Council were operational and meeting as required;
- established the registration requirements for 2009, including a new requirement for a Criminal Record Check and a CPR-C card or certificate, and clarifying the requirement of appropriate physician sign-off for Advanced Life Support Assessments for EMT-As and EMT-Ps;
- registered 1,571 members by December 31, and another 364 members since December 31;
- met the requirements for the Agreement on Internal Trade and referred scope of practice issues to the Ministry of Health for exceptions to be made or for other resolution;
- established processes for the Annual General meeting and held the first Annual General meeting where numerous resolutions were considered by the members attending;
- developed a policy manual for the College;
- investigated eight professional discipline complaints;
- established the continuing medical education (CME) requirements for 2010 and began to establish a field support system for CME;
- made a number of difficult and potentially controversial decisions, including an increase to professional fees; and
- provided written submissions to the EMS Review and the Patient First Review.

Health Sector Reviews

Three external reviews are occurring in the health sector all of which could have an impact on the work of the College. On December 11, 2008, the Government of Saskatchewan announced a review of emergency medical services focused on pre-hospital and inter-hospital transfers. This review will form the basis for a long-term plan to improve the province's road ambulance services. Although it is not widely held or top of mind for many residents, there is the beginning of a perception that the ambulance system in Saskatchewan is under stress, leading to unacceptably long response times in some emergencies. Other issues likely to surface through the review include comparability of service levels between rural and urban settings and the use of volunteer EMRs. The report is expected to be delivered to government in the fall.

Concurrent to the EMS Review, the Government of Saskatchewan is also conducting an Air Medical Services Review which will evaluate pre-hospital and inter-hospital air medical services in Saskatchewan and provide recommendations as to the service delivery for evolving air ambulance services in the province.

The Patient First Review is an independent evaluation of the Saskatchewan health care system commissioned by the Government of Saskatchewan in November 2008 for the purpose of enhancing patient-centred care at all levels of the system. The review has two parts. The first part of the review focuses on issues and challenges in the health care system from the perspective of patients (the "customers"), their family members, and advocates, based on their experiences with the system. The second part of the independent review will examine administration in health care and identify efficiencies, constraints and opportunities for improvement in the regional health authorities, their affiliates and the Saskatchewan Association of Health Organizations. The report is expected to be delivered to government in the fall.

The ministry has also indicated that they will be working on a Health Human Resource Plan that will clarify what skills are needed in the system. Their goal continues to be to have an EMT on every call in the province (Source: Minutes of meeting between the officials of the Ministry of Health and SCoP, August 11, 2009).

Agreement on Internal Trade (AIT)/Labour Mobility

Canada's premiers agreed in the summer of 2008 to take quick action to ensure full labour mobility in Canada by April 1, 2009. This means that a person certified in an occupation shall have their certification recognized in another province on its face without further assessment, training or experience requirements. Until scope of practice issues are dealt with by the Ministry of Health, exceptions from the AIT have been granted for EMRs, EMTs, and EMT-P. Out-of-province applicants will still have to show they meet Saskatchewan standards.

Part I – Paramedicine: Emerging Trends and Practices

Three interviews were conducted to identify emerging trends and practices. In addition, a small review of literature was conducted based on references received during the interviews. The following summarizes the themes that were heard during the interviews. In some instances, individuals who were being interviewed with regard to the governance objective reflected on these issues. Their comments have been included in this discussion.

Movement to Evidence-based Paramedicine

Traditionally, the practice of paramedicine has been determined by the medical director in a particular service. This is starting to change with more research suggesting a move to practice based on published research evidence. Currently, a project is being undertaken at Dalhousie University whereby a large database of interventions by paramedics has been created. These interventions have been categorized and searched for research that pertains to the interventions. Each study has been rated and given a grade for whether a paramedic should be doing a particular intervention. It is hoped this research will lead to a national set of guidelines that will be evidence-based. This work could eventually come to regulators to deal with issues on consistency of practice across the country.

The Emergency Medical Services Chiefs of Canada in their 2006 report, "Defining the Road Ahead," have also identified the lack of a research base and data collection capability required to systematically improve overall levels of care (Source: "Defining the New Road Ahead," 2006). They call for a system of paramedicine research and evaluation, continual improvement, and development of emergency care protocols and clinical pathways. They also endorse public reporting and the development of a Canadian accreditation system (Source: "Defining the New Road Ahead," 2006).

Development of National Quality Indicators

A national group has recently been formed to examine the issue of national quality indicators. Their mandate is to determine the kind of data to be collected to assess whether a quality service is being provided. The group is very new and will be meeting in Ottawa in October. The United States is farther ahead than Canada in establishing and collecting standard data across the country.

The EMS Chiefs of Canada recommend, as part of a strategy for systemic improvement, the development of comprehensive performance measures for EMS and enhanced data collection and research capabilities (Source: "Defining the New Road Ahead," 2006).

Community-based Paramedicine

Community-based paramedicine was identified in many interviews as an important new development. Examples in Saskatchewan were identified, including the use of a 40-foot motorhome in Saskatoon for use in the core neighbourhood; people not accessing clinics can receive basic health care services such as advice, vaccinations, etc. Innovation in the use of paramedics also occurs in intensive care in Saskatoon and overnight home care in Regina. These innovations appear to be driven by shortages in other health professions whereby paramedics are being used to supplement staffing. The most often referred to experience with community care was the Nova Scotia Long and Brier Islands project that is described in more detail in Appendix C.

The development of community-based paramedicine means that educational programming must also change. Paramedics will have to develop better client management and care skills as they are required to manage and interact with patients over longer periods of time. Examples were given of paramedics providing care over hours while waiting for room in hospital emergency rooms or providing "hallway care" in crowded emergency rooms. In addition, paramedics are increasingly being asked to offer consultation and solve problems with the patient. Comments from the College of Physicians and Surgeons clearly indicate the need for paramedics to be mindful of their scope of practice as they work in these new environments (Source: Minutes from Meeting between College of Physicians and Surgeons and SCoP, July 10, 2009).

The EMS Chiefs also recognize the need for greater community involvement through implementation of mobilized health care. They recommend that EMS leaders pursue opportunities to provide enhanced types and levels of health care, including public health and safety education, emergency response preparedness, disaster management and pandemic response capability (Source: "Defining the New Road Ahead," 2006).

Rural Services

The particular challenges for rural delivery of emergency medical services were identified a number of times in various interviews. Particular issues included recruitment and retention of EMT-Ps. The use of trained personnel in other non-professional roles was also raised (e.g., EMT being used as a janitor between calls). There was a sense that a capcity gap exists between larger urban services and smaller rural services that has implications for continuing medical education. Also the practice of paramedicine in rural areas poses challenges around the large geographic areas that need to be covered and particular approaches that are required in some areas, including reserve communities.

Collaborative Service Delivery

The EMS Chiefs recognize that core service excellence must be maintained but at the same time paramedics must "seek innovation through collaboration with primary health care providers, social service agencies and public safety groups that will enable innovative initiatives that have the potential to improve the level of health care within a community" (Source: "Defining the New Road Ahead," 2006). In a mobilized health care model, the role changes from transport to being part of the health care team.

Labour Mobility, Labour Market Demand and Post-secondary Education

Labour market demand was identified with regard to advanced care paramedics but not with regard to primary care paramedics (EMTs) and intermediate care paramedics (EMT-As). The current enrolment of 15 to 20 EMT-Ps is not sufficient and will have to double in the next five years.

Issues were also identified with labour mobility and in particular the implementation of the Agreement on Internal Trade. Full compliance with the AIT will likely mean aligning scope of practice and titles with national standards. This will have significant implications for the EMT-A designation as it does not exist at the national level. Moving in this direction means changes to educational programs, determining whether all professionals at those levels need to bridge, bridging programs for the those that do bridge, and costs for employers and operators.

Two viewpoints were heard on whether access to online programming was important. One view suggested online programming had not been identified by employers as a priority need, while others suggested that an online learning option was overdue and would be particularly useful for practitioners in rural areas looking to advance their credential.

Gaps were identified in career progression for paramedics. One option being pursued in Nova Scotia is to move to more formal post-secondary training as in university education. Dalhousie University is currently working on a program and the University of Toronto Scarborough Campus (UTSC) has a joint program with Centennial College. Students can earn a BSc Honours Degree from UTSC, as well as a paramedic diploma from Centennial College. Quebec is also developing a university model for paramedic education. Australia is a world leader in university-trained paramedics. Some mention was made of the merits of articulating paramedic training with training for other health care professions.

The EMS Chiefs have also dealt with personnel development by describing the paramedic of the future. They recommend training and education to give paramedics the competencies for community-based practice and a layered system of education that promotes the transferability of EMS credit. They recommend all provinces and territories should recognize and adopt the Paramedic Association of Canada National Occupancy Competency Profile. Consistency in education and training, a higher standard of education and training, and credential portability were all considered important values (Source: "Defining the New Road Ahead," 2006).

Part II – Governance Best Practices and Assessment

Best Practices in Self-Regulation

The project consultants conducted a short review of the literature on self-regulation (the literature is not extensive) and then conducted a series of interviews with internal and external stakeholders to provide the Council with an assessment of their current state as it relates to self-regulation.

Role of the Regulator

The principles summarized from the literature governing the role of the regulator are as follows.

Supremacy of the Legislature
Legislative supremacy means the legislature of the province is fully responsible for legislation delegating the responsibilities of the regulation to a professional body. In many cases the regulatory bodies are dependant on the legislature for the enabling legislation but also on continued government support for approving bylaws. The legislature can control what the regulators do and has the power to require something to be done when necessary. Even though the regulatory body has significant autonomy from government, it is still accountable to the public and to the government who has delegated its authority. This is usually done through reporting to government or to a minister or ministry. Another mechanism for ensuring public accountability is through the appointment of members of the public to the council of the regulatory agency (Source: "Understanding Professional Self-Regulation," Randall, 2000).

Public Interest
All health professions are regulated on the premise that it is in the public interest to do so. The Ontario Health Professions Regulatory Advisory Committee (HPRAC) notes that "the profession's leadership must be able to distinguish between the public interest and the profession's self-interest, and in self-regulating will favour the former over the latter." Regulatory bodies are expected to act in the public interest and not in the interest of the professional. In some cases the public interest and the professional interest may be the same but where they are not the same, the regulator has to prioritize the public interest (Source: "Understanding Professional Self-Regulation," Randall, 2000). The Conference Board of Canada notes that there is no single definition of public interest.

Protection from Risk of Harm
Protection from harm is often described as a subset of public interest (Source: Conference Board of Canada). The Council for the Regulation of Healthcare Professionals states that "the purpose of the system of regulation must be to assure the public of the competence of healthcare professionals and, when necessary, to protect them" (Source: The Bristol Royal Infirmary Inquiry, Final Report, United Kingdom: Chapter 25). To be self-regulating, the professional body must be able to show that a substantial risk of physical, emotional or mental harm to individual patients/clients arises in the practice of the profession (Source: HPRAC). The members of the new profession support self-regulation for themselves with sufficient numbers and commitment so that widespread compliance is likely. There are sufficient practitioners of the profession to staff all committees of a governing body with committed members willing to accept the full costs of regulation (Source: HPRAC).

Expert Body of Knowledge/Professionalism
The members of the 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 (Source: HPRAC).

Professionalism pertains not just to the regulation of individuals but also regulating the profession to which those individuals belong. The individuals forming the profession have evolved over time and developed a specialized body of knowledge that makes members of the group to be experts (Source: "Understanding Professional Self-Regulation," Randall, 2000). Prestige and status comes with achieving self-regulation and are often the most obvious benefits to the individual practitioner (Source: "Understanding Professional Self-Regulation," Randall, 2000).

Responsibilities of the Regulator

The main functions of the regulatory body are to:

- set requirements for individuals to enter the profession;
- set requirements for the practice of the profession;
- set up a disciplinary process; and
- set up a process to evaluate the ongoing competence of members.

Often the most controversial and difficult activity the regulator will have to do is to establish the method and process for determining the continuing competence of members. It is difficult because of the potential impact on the member and often because of the high costs associated with obtaining the credits and potential impact on an individual and their ability to practice their profession (Source: "Understanding Professional Self-Regulation," Randall, 2000).

HPRAC also acknowledges that the profession must demonstrate an understanding and appreciation of the economic impact of regulation on the profession, the public and the health care system, which suggests these factors need to be considered in the regulator's decision-making.

Assessment of SCoP's Current Self-Regulation Practices

Nine interviews were conducted with regard to the current state of SCoP's self-regulation practices. As noted previously, comments on self-regulation did arise in the practice interviews and where they occurred, the content is reported in this section. In this section of the interview, questions were asked with regard to the role of SCoP, the major responsibilities of SCoP and how well SCoP was performing these responsibilities in light of the principles described above.

Role of SCoP

The single most important theme that was heard almost consistently throughout the interviews was the support that interviewees had for the establishment of the College, and for the important and difficult role that the College had taken on. References were made to the long and sometimes difficult history that the profession had in reaching self-regulation and so there was considerable celebration of the achievement.

Comments were also made about the difficult transition, from oversight by the Ministry of Health, where regulation was not strictly enforced, to the much stricter enforcement regime provided by the

College. This was not offered as a criticism of the College but as an acknowledgement of the abrupt transfer of responsibility to the College, the cultural change created for operators and individual practitioners and the limited resourcing available to the College to take on the role. Repeated comments were made that the College was a new organization and was doing well for a regulator that is in its "infancy."

Differing views were offered as to the breadth of the College's role and the nature of the public interest it serves. At times the public interest was described in the context of the patient's interests and protecting the public from harm. It was often described in the context of public safety. The public interest was also defined in relation to the responsibility to monitor the profession to ensure individuals are practicing within their scope of practice and within their competencies. A view presented suggested the College's role is limited to regulation of the individual practitioner and has no role in the overall system. A number of interviewees were supportive of a narrower role for the College in the first few years with broadening of scope after it has some experience and track record. Scope of practice emerged as a responsibility the College should take on but only after it has shown it can manage its current responsibilities.

It was noted that the College does not consistently consider the impact on the health system in its decisions. Another view expressed suggested that the College has not been able to articulate what the public interest is and is moving forward only to improve the status of the College. Some defined the role by listing or describing the functions of a regulator (e.g., continuing medical education, to determine the scope of practice). A further interviewee described the public interest as being able to respond to all medical emergencies in the province.

There was some debate as to whether the College has an advocacy role with regard to its members. One interviewee clearly suggested there is a legitimate role to advocate for a direction for its members and move the mandate of ambulance operators forward; another viewpoint suggested that the rank and file members believe that the College should advocate on their behalf. Some commentary suggested that the College has a responsibility to raise the profile of the profession.

When asked about professionalism, there was some variation in responses. Many described professionalism as it relates to an individual practitioner's appearance, demeanour and conduct on the job. It was also related to the College's responsibility to monitor practice and discipline members. It was noted that the College defines professionalism in the context of its Code of Professional Conduct.

In many interviews the intersection of roles between the College, the health authorities, private operators, SIAST (as the single training institution for paramedics), and the Ministry of Health emerged as an issue. It is clear from the interviews that there is a wide variety of opinion on how these agencies fit together and how they should or do work together. More detail will be reported in later sections of this report dealing with particular issues. There was no commentary on the relationship with the College of Physicians and Surgeons despite the role it plays with the College which was recently discussed in a meeting between the two regulatory agencies (Source: Minutes of meeting between College of Physicians and Surgeons and SCoP, July 10, 2009).

Major Interview Findings

- Overwhelming support for the establishment of the College.
- Consistent with the literature, no single definition of the College's mandate as it relates to the public interest, although a majority define the public interest as equivalent to public and patient safety.
- No clear consensus on how broad or narrow the role of the College should be, but a number of views tipped toward a narrow view of the role of the College, particularly in the first few years of development with some broadening of scope toward more system-wide issues in the out years, including scope of practice.
- Professionalism is understood by the majority as relating to an individual practitioner and his/her appearance, demeanour and conduct on the job.
- Recognition that the College is a new organization in its "infancy," has done a lot of work in its first year and will continue to improve.
- Professional advocacy was identified as a role but poses problems for the regulatory responsibility and public interest.
- Confusion and a lack of understanding on the interaction of the roles between the College, the health authorities, private operators, SIAST (as the single training institution for paramedics), and the Ministry of Health.
- No mention in interviews of relationship with the College of Physicians and Surgeons except in documents provided to consultants.

Responsibilities of SCoP

In this section, more specific questions were asked about the responsibilities of the regulator as described above and how well SCoP was doing with regard to these functions.

A lot of feedback was received with regard to registration, licensing and qualifications. Questions with regard to quality assurance and continuing medical education requirements triggered many comments. The particular issues that emerged include:

- confusion on previous practices of who could be the medical advisor as it relates to approving qualifications;
- moving to the ITLS requirements with little notification and consultation. The College was given credit for listening and responding to the issues raised by members of the system by moving back the requirement;
- imposition of new continuing education requirements that did not take into account the costs or budget cycles of the operators and health authorities;
- issues with the database operated by the College and its adequacy for the work the College needs to do;
- the differences in training capacity in urban Saskatchewan compared to rural Saskatchewan; and
- insufficient implementation plans once a decision is made and little understanding of the implications particularly on small and rural providers.

Feedback was received with regard to Continuing Medical Education and the roles and responsibilities of the College, SIAST, and the employer. Dimensions of the issue include:

- the perceived closeness in the relationship between SIAST as the single training institution and members of the Council was expressed as a concern in a number of interviews;
- an opposing view was expressed that the College and SIAST could be working even more closely and that the College was not taking advantage of all of SIAST's resources, particularly in relation to licensing examinations; and
- one interviewee believes the College does not have a role with regard to setting standards of practice and that standard setting was the sole role of SEMSA and the province. In this model, the main role for the College is registration and discipline. Their responsibility is individual quality assurance and is not systemic quality assurance.

Questions about investigation of complaints and discipline also triggered commentary from some of the interviewees. The main issues identified are as follows.

- Process followed by the Professional Conduct and Discipline committees of the College was of concern. The main issue was that decisions were made without due process to the member and without all the relevant information in front of the Professional Conduct Committee.
- Concerns were also expressed with regard to communication and notification to the employer when an employee and member is being investigated.
- Interviewees recognized the College is new at this process and will improve with experience.
- Concern was expressed with regard to the amount of training and support that the Professional Conduct Committee and Discipline Committee had received and the need to do more training.
- Concern was also expressed that due to the relatively young age of the membership, discipline processes could be used as a way to sort out personality conflicts. Therefore the College needs to establish a screening process to ensure complaints were serious and worthy of a professional investigation.
- Concerns were expressed with regard to the appropriate role of Council in the investigation and discipline process.

A strong view was expressed in this section of the interviews that there has been sufficient change introduced by the College in the last year, particularly with regard to Continuing Medical Education, and it should be an immediate priority of the College to communicate the requirements clearly and allow the system to stabilize over a couple of years. Often it was characterized as the "College must walk before it runs." This view was tempered by the acknowledgement that the College has moved the profession to real regulation where under the Ministry of Health there was a very loose system, both in terms of timeliness in registering and meeting all the registration requirements.

Interviewees were also careful to acknowledge all the work the College has done in the last year and that it has taken good steps to move the profession forward.

Major Interview Findings

- Concerns with regard to registration, licensing and continuing medical education system as it relates to clarity of communication of requirements.
- Concerns with appropriate levels of the consultation with stakeholders in the system before imposing new requirements.
- Concerns with whether the College understood and had considered all the implications of their decisions, particularly cost issues, budget timing issues, and implementation planning.
- Issues with the process followed by the committees of the College with regard to professional investigation and discipline.
- Major concerns with the rate of change introduced in the last year and the need to stabilize the accomplishments introduced in the last year.
- Recognition that the College has worked hard to introduce a real regulatory framework that has been a significant cultural change for the industry and membership.

Best Practices in Board or Council Governance

Numerous board governance models are set out in the literature. Many of them, like the Carver Model, take significant resources both financial and time, to fully and completely implement. Instead of describing those models, the consultants have chosen to describe best practices and trends for board governance as set forth in a recent study of board governance for volunteer and non-profit organizations. The best practices for this sector are summarized in a report called the "National Study of Board Governance Practices in the Non-Profit and Voluntary Sector in Canada," completed in 2006 by Strategic Leverage Partners Inc. The principles summarized in this report should provide the College with an understanding of the dimensions of board or Council responsibilities suitable for their current state of development. It should be noted that not all the report is completely relevant to the College, which has many of its responsibilities established in legislation (e.g., board size and elections to fixed positions as opposed to board recruitment and selection).

The best practices in this report have been compiled through a web-based survey and response from approximately 1,300 organizations across Canada, five key informant interviews with prominent Canadians involved in non-profit organizations, leadership commentaries in leading edge practices in the area, focus groups and community roundtables.

Principles and emerging trends in best practices can be summarized as follows.

Board Structure, Recruitment and Succession Planning
Board size is important to functionality. The optimum size is often recommended at approximately 10 people. Larger boards will often use an Executive Committee to ease decision-making between board meetings. Succession planning for board members is an important function that should occupy time on the agenda of the current board. Finding good people with leadership capabilities is critical and often boards will establish nominating committees to assist in recruiting new members with the right skill sets. It is important for the board to consider the kinds of skills

that are required and plan to recruit for those skills. The key to board selection is the active involvement by the current board in replacing themselves. It is the chair's responsibility to ensure good governance practices are in place, that board members are engaged and that the board functions well (Source: National Study).

Role Clarity, Board Policies/Processes and Board Culture

Board members understand the difference between management and board responsibilities. A good board "sets objectives for itself, understands the organization, helps management set strategy, and appoints, evaluates and monitors the CEO" (Source: National Study). Board orientation for new members, board education and development plans, and board assessments of themselves are all best practices. It is the chair's responsibility to develop the culture of the board. The board requires sufficient information to make informed decisions. The board needs to be in a position to ask informed questions of the CEO (Source: National Study).

Board Meetings and Board Engagement

Board meetings should be held regularly; should start on time; manage time by moving through the agenda; have an agenda and keep on topic; have an in-camera session at the end of meetings for an open-ended discussion; expect board members to arrive at meetings having read the material provided in advance; circulate minutes in a timely fashion and clearly track action items with board members' responsibilities. Strategies should be considered to ensure a fully engaged board whether that is regular communication, or social activities. Trust has to be created at the board and between the board members (Source: National Study).

Transparency, Accountability, Stewardship and Public Trust

Boards are accountable to their stakeholders and need to clearly understand who are their stakeholders. Board members need to be provided with sufficient financial information for them to understand the financial status of their organization. Boards should be transparent with their policies and processes. The board must work to obtain and maintain public trust. The organization should have a reputation for integrity, the ability to solve problems and manage issues. Financial accountability must be assured through use of an auditor and establishing a close relationship with the auditor (Source: National Study).

Strategic Planning

The board should engage in strategic planning – the best option is through a retreat that is facilitated to allow the chair to participate in the discussion and to keep the process on track (Source: National Study).

Risk Management

The National Study reports that an emerging trend for boards is to develop more risk management strategies. This means boards must develop skills and competencies in risk management, particularly in assessing risk and developing plans to manage risk (Source: National Study).

Partnerships, Networks and Collaborations

The report identifies use of partnerships, networks and collaborative models as an emerging trend in board governance. This means that boards must be ready to recognize opportunities to partner as their mandates will allow, and be ready and able to build relationships with other organizations and stakeholders (Source: National Study).

Assessment of SCoP's Current Governance Practices

Questions covered in the interviews dealt with the general governance role of the Council; Council policies and practices (e.g., stewardship and accountability, risk management, strategic planning, succession planning); strengths and weaknesses of the Council; communication and consultation practices; and priorities for the Council. Not all interviewees were in a position to have sufficient knowledge to respond to all questions; in that case they were asked to only comment on those questions where they had direct knowledge.

Throughout the interviews the commitment of the Council was consistently identified as a strength and applauded. In addition, comments were made that the Council was composed of practitioners and that was thought to be a strength of the Council.

The major themes identified from the interviews are as follows.

- Because of the newness of the organization, policy and decision-making processes were seen to need strengthening. In virtually every interview the decision-making style of paramedics (i.e., quick decisions on the spot and usually in a crisis) was described as critical to success on the job but a problem in the context of the Council. The impact of quick decisions and the resulting unintended consequences were often cited as causing problems for the College. Raising fees was cited in this regard along with the decisions on continuing medical education already described.
- The Council was not seen as sufficiently diverse to represent the full range and membership of the profession.
- Consultation and communication were also raised as issues. A number of interviewees felt the College had not consulted sufficiently with stakeholders before making significant changes that had consequences for the industry. Many acknowledged the College had the authority to make the decision but they wanted to be included to add their perspectives. Without consultation, the College could not be aware of all of the implications and consequences of their decision.
- The Council needs governance training, training on their role and training on risk management.
- The Council understands the budget and the financial management of the College.
- Strategic planning has occurred but has been very basic; the scheduled session was seen as an opportunity to develop a more robust plan.
- There is no performance measurement plan for the Council. Self-assessment of Council performance has been done but it was not completely successful.
- Role of the Council needs to be more fully described and understood by Council members. Its role needs to be clarified in relation to health authorities, employers, SIAST, and the health ministry.

When asked about priorities over the immediate term (six months to a year), mid-term (three to five years) and long term (over five years), there was a strong consensus that the College needs to use the next few months and years to stabilize the practices and changes already introduced. Immediate attention to communication to licensing and registration issues was seen to be critical, as well as more communication of the CME requirements. Mid-term directions varied more and included more attention to scope of practice issues, development of a more robust continuing education model and quality assurance model. Long-term direction was similar to the mid-term.

Major Interview Findings

- The Council is viewed as having strengths that can be built upon in the future.
- Decision-making processes without full consideration of the system and industry implications were viewed as a weakness.
- Interviewees want to see improvement in communication and consultation practices.
- Role clarification needs to occur between SCoP and its major stakeholders.
- Council needs more training on its role.
- College should prioritize stabilization of the current requirements over the next few years before it introduces further change to the self-regulation system and industry.

Conclusion

The consultants found the College has many strengths that can be built upon in the future. Interviewees were all very supportive of the College taking on the responsibility of self-regulation. Many recognized the difficult task the College has accepted and the hard work performed by the Council and its staff over the last year. Interviewees were pleased to participate in the process of preparing this paper; they were also pleased that the process was occurring and thought the strategic planning session was an excellent step for the College.

Attention to relationships with stakeholders, better consultation and communication processes, more robust decision-making practices, clarifying roles and responsibilities of the College with its stakeholders, and stabilizing licensing and registration requirements will pay dividends as the College moves forward.

Appendix A – List of Interviewees

Brent Stewart, President, Saskatchewan College of Paramedics

Lily Stonehouse, Executive Director/Registrar, Saskatchewan College of Paramedics

Jan Jensen ACP BSc, Division of EMS, Dalhousie University, Masters of Applied Health Services Research Student, Atlantic Research Training Centre, Dalhousie University

Tim Hillier, MD Ambulance, Saskatoon

Duane Fleming, SIAST

Patrick O'Byrne, Ministry of Health

Ron Knaus, Ministry of Health and Ya-Hong Song, Ministry of Health (together)

Glen Perchie, Regina Qu'Appelle Health Region

Garth Palmer, Moose Jaw Fire

Wayne Nogier, Kelsey Trail Health Region

Rod MacKenzie, Saskatoon Health Region

Trevor Dutchak, SEMSA, Parkland Ambulance

Appendix B – Resources and Documents Reviewed

SCoP Documents

Saskatchewan College of Paramedics, Annual Report, March 31, 2009.

Assessment of SCoP Current Status Against Criteria for Regulating a New Profession, SCoP Document, Summer 2009.

Saskatchewan College of Paramedics, Presentation to SEMSA Convention, 2009.

Saskatchewan College of Paramedics, Council Evaluation Checklist, April 2009.

Saskatchewan College of Paramedics, Brief to the Patient First Review.

Saskatchewan College of Paramedics, Brief to the EMS Review.

Saskatchewan College of Paramedics Brief, A Profession to be Proud Of.

Minutes from meetings between Ministry of Health and SCoP, dated August 11, 2009.

Minutes of meeting between College of Physicians and Surgeons and SCoP, July 10, 2009.

Correspondence between SCoP and various Fire Departments.

Articles

Bugg, Grace and Dallhoff, Sue, "National Study of Board Governance Practices in the Non-Profit and Voluntary Sector in Canada," Strategic Leverage Partners Inc., 2006.
www.cvsrd.org

Conference Board of Canada, "Achieving Public Protection Through Collaborative Self-Regulation," 2007.

Health Professions Regulatory Advisory Council, Criteria Review, December 2004.

Jensen, Jan et al, "The Canadian Prehospital Evidence-based Protocols Project: Knowledge Translation in Emergency Medical Services Care," ACAD EMERG MED, July 2009, Vol. 16, No. 7.
www.aemj.org

Martin-Misener, Ruth et al, "Cost Effectiveness and Outcomes of a Nurse Practitioner-Paramedic-Family Physician Model of Care: the Long and Brier Islands Study," Primary Health Care Research & Development 2009; 10; pp. 14-25.

Myers, J. Brent et al, "Evidence-based Performance Measures for Emergency Medical Services Systems: A Model for Expanded EMS Benchmarking," Prehospital Emergency Care, April/June 2008, Volume 12/Number 2, pp. 141-151.

Randall, Glen, "Understanding Professional Self-Regulation," unpublished, 2000.

The Bristol Royal Infirmary Inquiry, "Competent Healthcare Professionals," Chapter 25, Final Report: The Council for the Regulation of Healthcare Professionals. **www.bristol-inquiry.org.uk/final_report/report/sec2chap25_23.htm**

Other Sources

Government of Saskatchewan News Release "Saskatchewan Achieves Important Labour Mobility Milestone," August 4, 2009.

University of Toronto Scarborough Campus Website
www.utsc.utoronto.ca/~jtprogs/paramedicine

Appendix C – Description of Brier and Long Islands Project, Nova Scotia

The Brier and Long Islands Project, Nova Scotia, was often cited as an excellent example of paramedics practicing in a collaborative, community-based health care team approach in a rural and isolated setting. The following is a short description of the project and the outcomes achieved.

Project Description

The Brier and Long Islands are off the east coast of Nova Scotia in a remote setting with a small population (1,240 residents). Getting to the islands requires travel by road and a short ferry ride to the islands. The community was not satisfied with the level of primary health service that was being provided. A decision was made by the Nova Scotia government to use the paramedic service that was stationed on the islands differently. The service was averaging one call every three days.

Initially, paramedic services were limited to the kinds of things they could do in an ambulance. After 18 months, a former physician's clinic was renovated to form a headquarters where paramedics began to operate clinics and use it as a base for home visits. Paramedics received additional education and started to assess and manage simple wounds, administer tetanus injections and flu immunizations and perform home assessments. In the third phase a nurse practitioner was added through a collaborative practice agreement with a doctor on the mainland. With the nurse practitioner, paramedics (with additional training) were able to perform wound care and blood draws under the direction of the nurse practitioner. Their services expanded to include assessment of patients with congestive heart failure and diabetes, assist with medication compliance, administer antibiotics, assess urine specimens, change dressings and remove sutures and staples.

Outcomes

Researchers tracked the project and made the following findings.

- The number of family physician office visits and emergency department visits by residents decreased.
- Participants reported increased access to a range of health services, as well as an increase in utilization of the nurse practitioner and paramedic services.
- Participants reported an increased acceptance of the new model of care over the duration of the project and over time reported the services they received during the project were better than the services they had received previously.
- Residents expressed general levels of satisfaction with the services.
- Participants stated that the nurse-practitioner model of service was well-suited to the rural setting; roles between practitioners required clarification over the duration of the project.
- Participants reported improved collaboration between health care professionals over the duration of the project.