HB 1241 Nurse Triage

House Human Services 1/19/2021

Representative Marvin E. Nelson, District 9

Chairman Weisz,

My support of Nurse Triage really began with a presentation by State Health Officer Dr. Terry Dwelle, to an interim committee. He gave a nice presentation on how it could lower costs and improve care. Unfortunately, the program did not make the Governor's budget that year and so the Health Department could not support the program.

Here we are, a few years later and our Medicaid program has problems. High costs and not great outcomes. A nurse triage program could improve both. But there are a lot of moving parts so this bill doesn't try to just force it into HHS, but does say HHS will look at it.

One thing you hear often is people complain that Medicaid patients just go to the emergency room. There is some truth to that. It has been shown that nurse triage programs can reduce the utilization of emergency rooms. It comes down to appropriate care.

It is too bad we did not have this in place during Covid. We have both over utilization and under utilization taking place. Having access and being encouraged to use North Dakota licensed RN's could have significantly helped people make appropriate decisions.

It should also be noted that another aspect is contacting patients after hospitalization. I spoke with a person running a nurse triage program who said when they called people after hospitalizations, 12% of the time he said he would hang up the phone and dial the ambulance. I said doesn't sound like you are saving money and he said, you should see the bill after you let them stew for 3 or 4 more days before the ambulance.

I have included a couple of informative pieces on Nurse Triage, one is an abstract of a study on cost effectiveness and satisfaction. It showed $1.70 in savings for each dollar invested. I've seen claims of returns as high as $19/$1. Realize that different programs have different goals. The highest return was a claim of preventing a doctor's practice from losing patients to the emergency room.

Another is a comparison of patient intentions before the call as contrasted to recommendations by the nurse. The two are very different. Patients planning on using emergency often did not need to, and more than a few patients not intending to use emergency needed to get immediate care. People are lacking in medical knowledge and this is one way to get knowledge applied to immediate situations.

This is part of what make evaluation difficult. If you take two patients and flip which one goes to the emergency room, it looks like you didn't save any money.

Things that would influence the adoption of such a program are for instance getting a Medicaid waiver. Seeing just what is available today and working out how to integrate it into the current system.