COMMUNITY PARAMEDIC STUDY - BACKGROUND MEMORANDUM

The Health Services Committee has been assigned, pursuant to 2013 Senate Concurrent Resolution No. 4002 (Appendix A), a study of the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state, including the ability to receive third-party reimbursement for the cost of these services and the effect of these services on the operations and sustainability of the current emergency medical services (EMS) system.

BACKGROUND INFORMATION

North Dakota Century Code Chapter 23-27 (Appendix B) provides the State Department of Health is the licensing authority for emergency medical services operations and may designate their service areas.

Emergency Medical Services Licensing

Section 23-27-03 provides the fee for an emergency medical services operation license to operate an emergency medical services operation or a substation ambulance service operation must be set by the Health Council at a sum not to exceed $25 annually. The fee, currently set at $25, is to defray the administrative costs of the licensing program. All license fees must be paid to the State Department of Health, deposited with the State Treasurer, and credited to the state general fund. Emergency medical services personnel are not subject to a license fee. The Health Council is responsible for establishing rules for licensure.

In addition to licensing five industrial ambulance services, which only respond to property owned by the company they serve, and 78 quick response units, the state also provides licenses for two levels of ground ambulance service--basic life support and advanced life support. Basic life support ambulances must have a minimum staff training level of an emergency medical technician and a driver certified in CPR, while advanced life support ambulances must have a minimum staff training level of a paramedic and an emergency medical technician. The state currently has 20 advanced life support ambulance services and 118 basic life support ambulance services, of which 8 basic life support ambulance services are substation ambulance services, meaning they are licensed as a secondary base location from which an ambulance can be dispatched, but 24-hour coverage is not required.

Emergency Medical Services Training and Certification

Section 23-27-04.2 requires the State Department of Health to assist, within the limits of legislative appropriations, in the training of emergency medical services personnel of certain emergency medical services operations and to financially assist certain emergency medical services operations in obtaining equipment. In addition, Section 23-27-04.3 requires the Health Council to adopt rules prescribing minimum training, testing, certification, licensure, and quality review standards for emergency medical services personnel, instructors, and training institutions.

Supervision of Emergency Medical Technician Hospital Personnel

Section 23-27-04.4 allows certified or licensed emergency medical technicians-intermediate and paramedics, who are employed by a hospital, to provide patient care within a scope of practice established by the State Department of Health. These emergency medical services professionals are under the supervision of the hospital's nurse executive.

The Legislative Assembly in 2011 House Bill No. 1044 created Chapter 23-46 (Appendix C) related to emergency medical services. Section 23-46-03 requires the State Department of Health to establish and update biennially a plan for integrated emergency medical services in the state. The plan must identify ambulance operations areas, emergency medical services funding areas that require state financial assistance to operate a minimally reasonable level of emergency medical services, and a minimum reasonable cost for an emergency medical services operation. In addition, Section 23-46-02 requires the State Department of Health to establish an Emergency Medical Services Advisory Council and consider the recommendations of the council on the plan for integrated emergency medical services in the state, development of emergency medical services funding areas, development of the emergency medical services funding areas application process and budget criteria, and other issues relating to emergency medical services as determined by the State Health Officer.

PREVIOUS STUDIES

The 2007-08 Public Safety Committee was directed to study the state's EMS system, including the funding, demographics, and impact on rural areas. The committee recommended 2009 Senate Bill No. 2049 relating to emergency medical services programs. The bill was not approved by the 2009 Legislative Assembly but would have provided a $4,524,000 appropriation from the insurance tax distribution fund to the State Department of

Health to provide emergency medical services operations grants, to implement an emergency medical services assessment process, to provide leadership training, and to develop a statewide emergency medical services recruitment drive. However, the Legislative Assembly in 2009 Senate Bill No. 2004 increased funding provided from the insurance tax distribution fund for emergency medical services by $1.5 million. Section 6 of the bill authorized $2.25 million for **emergency medical services operations grants** as provided in Chapter 23-40 during the 2009-11 biennium and $500,000 for a grant to contract with an organization to develop, implement, and provide an access critical ambulance service operations assessment process for the purpose of improving emergency medical services delivery; to develop, implement, and provide leadership development training; to develop, implement, and provide a biennial emergency medical services recruitment drive; and to provide regional assistance to ambulance services to develop a quality review process for emergency medical services personnel and a mechanism to report to medical directors. This funding was in addition to $1.24 million provided for **emergency medical services training grants**, of which $940,000 was from the general fund and $300,000 was from the community health trust fund. The section also provided the State Department of Health require recipients of grants to provide information on the use of funds received as necessary for the State Department of Health to provide a report to the Legislative Management on the use of the funding.

The 2009-10 Public Safety and Transportation Committee was assigned a study, pursuant to Section 5 of 2009 Senate Bill No. 2050, of emergency medical services funding within the state, including state and local emergency medical services and ambulance service funding and the feasibility and desirability of transitioning to a statewide funding formula.

The committee was also assigned to receive a report from the State Department of Health, pursuant to Section 6 of 2009 Senate Bill No. 2004, regarding the use of funding provided for grants to emergency medical services operations during the 2009-11 biennium. The committee learned in fiscal year 2010 a total of 41 ambulance services of the 147 licensed with the State Department of Health applied for emergency medical services operating grants. A total of $1,104,259 in grants was awarded to 39 ambulance services. The grants ranged from $2,080 to $45,000 with an average grant award of $28,314. Ambulance services were required to provide matching funds that ranged between 10 and 90 percent based on the needs of the ambulance service.

The committee learned the State Department of Health awarded a grant to SafeTech Solutions, LLP, pursuant to Section 6 of 2009 Senate Bill No. 2004, which identified $500,000 from the insurance tax distribution fund for a grant to contract with an organization to study emergency medical services issues. The committee learned eight one-day summits were held by SafeTech Solutions to receive input from local ambulance services regarding rural emergency medical services challenges, and a final report, including recommendations for changes, was made available in late 2011.

The committee received testimony regarding challenges faced by emergency medical services, including dangers faced by ambulance personnel; increasing number of calls in areas affected by oil and gas development; and the lack of personnel, adequate leadership, and funding.

The committee learned funding sources for emergency medical services include property taxes, county sales tax, federal homeland security grant funding, Medicaid payments, emergency medical services training grants, and emergency medical services operations grants. Other sources of revenue for ambulance services include donations, federal funds, and user fees that include insurance payments. Ambulance services may directly bill patients who are not covered by a third-party provider.

The committee explored funding options for emergency medical services, including increasing funding for Medicaid and a statewide funding plan for emergency medical services in which state funding for emergency medical services would be provided to an area of the state rather than to specific ambulance services. Each funding service area would allow ambulance services to collaborate and reduce redundancies, maintain local decisionmaking, and facilitate the integration of ambulance services if needed. Each service area would also provide matching funds which could be from sources as determined by the local area.

The committee recommended House Bill No. 1044 to provide the State Department of Health establish and biennially update a plan for emergency medical services in the state, establish an Emergency Medical Services Advisory Council to provide advice to the department regarding emergency medical services issues, ensure all areas of the state are covered by reasonable ground ambulance response, and allocate state financial assistance for each emergency medical services funding area based on the financial needs of each emergency medical services funding area and require local matching funds of at least $10 per capita. The bill included an appropriation of $12 million from the insurance tax distribution fund to the State Department of Health for providing state financial

assistance for emergency medical services and repealed Chapter 23-40 relating to the current process of providing financial assistance to emergency medical services.

As approved by the 2011 Legislative Assembly, House Bill No. 1044 repealed Chapter 23-40 relating to the current process of providing financial assistance to emergency medical services and created Chapter 23-46 related to emergency medical services. The bill directed the State Department of Health to establish and update a plan for integrated emergency medical services in the state, which includes designation of emergency medical services funding areas, and created an Emergency Medical Services Advisory Council to advise the State Department of Health on the state plan for integrated emergency medical services, development of emergency medical services funding areas, development of the emergency medical services funding areas application process and budget criteria, and other issues relating to emergency medical services. As approved, the bill appropriated $3 million from the general fund for state assistance grants to emergency medical services operations and related administrative costs to the State Department of Health during the 2011-13 biennium.

In addition, 2011 House Bill No. 1004 provided $1,250,000 from the insurance tax distribution fund for emergency medical services staffing grants and $940,000 from the general fund for emergency medical services training grants for the 2011-13 biennium. House Bill No. 1266 (2011) provided $100,000 from the general fund to support a comprehensive state trauma system and authorized the State Health Officer to appoint an emergency medical services and trauma medical director to provide medical oversight and consultation in the development and administration of the state EMS and trauma systems.

The 2011-12 Health Services Committee received information regarding the emergency medical services improvement grant to study rural emergency medical services issues awarded to SafeTech Solutions, LLP, from the Emergency Medical Services Advisory Council. The SafeTech Solutions, LLP, report on the challenges facing EMS in rural North Dakota expressed a concern regarding the lack of adequate rural, out-of-hospital EMS in North Dakota. The committee learned in rural areas, where volumes of medical transports are low, EMS relies on donations, local tax revenues, and volunteer labor. In western North Dakota, increasing demand for services is a concern, including a need for specific training and environmental challenges. In other parts of the state, the aging population is an issue.

The committee learned 86 percent of the ambulance services in the state rely primarily on volunteers whose labor cost would exceed an estimated $31 million per year. Aging volunteers and the decline in volunteerism has resulted in a shortage of EMS workers. The committee learned characteristics of successful rural services include engaged, trained, dedicated, and rested leaders; professional standards; recruitment and retention plans; organization; adequate funding; and well-maintained facilities and equipment. The advisory council was directed by the 2011 Legislative Assembly to make recommendations to the State Department of Health regarding the establishment of funding areas and criteria to determine funding levels for each area. The committee learned the Energy Infrastructure and Impact Office made $2 million of funding from the oil and gas impact grant fund available for EMS, and an additional $30 million contingent appropriation from the oil and gas impact grant fund was provided for oil and gas impact grants related to emergency services during the November 2011 special session.

The committee received information from the State Health Officer regarding community paramedics. The committee learned there is the potential for community paramedics to provide additional cost-effective clinical and public health services, particularly in rural areas of the state. The ability to receive reimbursement for these services could enhance the sustainability of the current EMS system. The committee learned EMS systems can function with volunteer personnel by responding to up to approximately 350 emergency calls per year, while fee-for-service systems are generally not sustainable until the service responds to at least 650 emergency calls per year. Increased demand is causing some communities with volunteer responders to increase to more than 350 emergency calls but still less than 650. The committee learned if the role of paramedics could be expanded to that of community paramedics, fee-for-service EMS systems could likely be sustained. The committee learned appropriately trained community paramedics could provide billable services, including:

1. Community mid-level clinical evaluation and treatment;
2. Community level call-a-nurse service and advice;
3. Chronic disease management support;
4. Case management of complex cases;
5. Worksite wellness facilitation and onsite clinical support; and
6. School wellness and mid-level clinical services.

The committee learned issues to be resolved relate to needs, certification, regulation, and reimbursement.

The committee recommended Senate Concurrent Resolution No. 4002 for a Legislative Management study of the potential for community paramedics to provide additional clinical and public health services particularly in rural areas of the state, including the ability to receive reimbursement for these services and the effect these reimbursements would have on the sustainability of EMS providers. The resolution, as approved, providing for the study was assigned to the Health Services Committee.

2013 LEGISLATION

Community Paramedic/Community Health Care Worker Pilot Project

The Governor recommended and the Legislative Assembly approved, in 2013 Senate Bill No. 2004, $276,600 from the general fund for one full-time equivalent (FTE) position ($135,000) for the State Department of Health to implement a community paramedic/community health care worker pilot project and educational startup costs ($141,600) during the 2013-15 biennium. The State Department of Health's request for the FTE position is to coordinate the ongoing community health care providers, establish a training program for the project, and coordinate ST-elevation myocardial infarction (STEMI).

The State Department of Health request for pilot project funding indicated the program would coordinate workers to utilize the downtime of paramedics between ambulance calls in order to assist community health workers. The department indicated there appears to be significant overlap between community health care workers and community paramedics, so it seems natural for these two divisions to collaborate on a new health care delivery system in both rural and urban areas. The department held a statewide stakeholder meeting asking for provider input regarding the concept of a patient-centered medical home model, or in some cases seeking a decrease of chronic use of ambulance transport or unnecessary utilization of emergency departments. This model is currently being utilized in some surrounding states, Minnesota and Montana, as well as rural areas (Eagle County, Colorado) utilizing both the urban and rural focus of this concept. The department indicated there is a need in the state to help transition patients from the clinical system into the community to avoid continued chronic disease readmissions into the clinical systems. Efforts throughout the country to establish an alternative to the existing health care delivery system include a medical home model or a transition model of care; however, most of the new models require an additional workforce and compensation. The department indicated collaboration between the community health worker and community paramedics would effectively use the workforce that currently exists with significant downtime between ambulance calls or transports. The emergency medical services workforce already exists and can possibly benefit from this concept which may keep ambulance services sustainable. The department indicated the project would fill the needs of the community by training the current workforce and reinforcing the dwindling number of volunteers by injecting some paid staff for ambulance services. The department indicated a curriculum exists for the training of the providers; however, changes to existing rules and statutes may be necessary to make the program fully functional.

Emergency Medical Services Grants

The Legislative Assembly did not change the executive recommendation for rural emergency medical services grants. Senate Bill No. 2004 (2013) provides a total of $7,340,000, of which $6,090,000 is from the general fund and $1,250,000 is from the insurance tax distribution fund, for rural emergency medical services grants, including training grants ($940,000). This level of funding represents an increase of $2.15 million from the general fund compared to the 2011-13 biennium. In addition, House Bill No. 1358 provides $7 million from the oil and gas impact grant fund for grants to emergency medical services providers for extraordinary expenditures that would mitigate negative effects of oil development affecting emergency medical services providers providing service in oil-producing counties, including the need for increased emergency medical services providers services, staff, funding, equipment, coverage, and personnel training.

Comprehensive State Trauma System

The Legislative Assembly in 2013 Senate Bill No. 2226 provided an appropriation of $332,000 from the general fund to the State Department of Health for a comprehensive state trauma system to provide a total of $432,000 from the general fund during the 2013-15 biennium. Funding is provided for a contracted emergency medical services and trauma medical director, advanced trauma life support training, development of the rural trauma team development course, trauma designation visits, and a state trauma registry.

STUDY PLAN

The committee may wish to proceed with this study as follows:

1. Gather and review information regarding clinical and public health services that may be performed by community paramedics, particularly in rural areas of the state, including the types of services community paramedics could perform, additional training necessary to perform additional services, and any legislation required to allow community paramedics to perform additional services.
2. Gather and review information regarding the ability to receive third-party reimbursement for the cost of clinical and public health services performed by community paramedics and the effect of performing these services on the operations and sustainability of the current emergency medical services system.
3. Receive information from the State Department of Health regarding community paramedic programs operating in other states, including the benefits and challenges experienced by states implementing community paramedic programs and the status of the community paramedic and community health care worker pilot program.
4. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
5. Prepare a final report for submission to the Legislative Management.

ATTACH:3