2013 HUMAN SERVICES

SCR 4002

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SCR 4002
1/14/2013
Recording Job Number: 17164

☐ Conference Committee

Committee Clerk Signature: Lawrence

Explanation or reason for introduction of bill/resolution:

A concurrent resolution directing the Legislative Management to study the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state.

Minutes: You may make reference to "attached testimony."

Chairman Lee opens the hearing on SCR 4002.

Shiela Sandness, a Senior Fiscal Analyst for the Legislative Council, introduces SCR 4002 to the committee and is neither for nor against the resolution.

See attached testimony #1.

Floor is open for questions from the committee.

Senator Dever asks Ms. Sandness for clarification of the study and there is a discussion.

Chairman Lee explains that they may need to coordinate with the Appropriations Committee that's reviewing the health department's budget.

No further questions from the committee for Ms. Sandness.

Tim Wiedrich, Section Chief of the North Dakota Department of Health's Emergency Preparedness and Response Section, is next up to provide information regarding the resolution.

See attached testimony # 2.

Floor is opened for questions from the committee.

Chairman Lee asks Mr. Wiedrich if he has visited with either the medical association or the nurses association about the community paramedics concept.

Mr. Wiedrich states that they have visited with these associations. Some are voicing a great deal of support along with some concerns in terms of how it impacts the specific skill set. The intent is to fill a niche that is not currently being served and not to impede on any other certification or licensure provided by other entities. As these conversations continue, there will be more and more understanding about what these concepts actually are.

Senator Dever asks Mr. Wiedrich about the paramedic's scope of practice.

Mr. Wiedrich explains that their approach is that they are not interested in changing the scope of practice, per say. Many of the skills being discussed have a direct correlation; however, there may be other areas that they will have to expand the knowledge base and the activity as the range of services get further explored. The legislature has delegated a process through an administrative rule making procedure where the Department has the ability to generate administrative rules through the health council. There is a "scope of skills" that is fundamentally within the realm of EMS providers.

Senator Anderson feels this is an attempt to bring some consistency to an ambulance service by reimbursing them adequately so that they can provide some extra services that aren't there. There is a need to look to see if this is a service that will be beneficial.

No further questions from the committee for Mr. Wiedrich.

Shelly Peterson with the North Dakota Long Term Care Association is next up to testify in support of the resolution.

See attached fact sheet #3.

No questions from the committee for Ms. Peterson.

No more testimony in favor or opposition on SCR 4002.

Chairman Lee closes hearing on SCR 4002.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SCR 4002
1/14/13
Recording Job Number: 17181

☐ Conference Committee

Committee Clerk Signature: Kari Kuch

Explanation or reason for introduction of bill/resolution:

A concurrent resolution directing the Legislative Management to study the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state.

Minutes: You may make reference to "attached testimony."

Committee discussion on SCR 4002.

Committee clarifies that a resolution is always optional.

Senator Larsen likes the idea of it and is curious to know how this is going to reduce the unnecessary and expensive ER visits.

Chairman Lee provides an example from when she visited with people from FM Ambulance.

Senator Anderson follows by providing another example and explains that part of the goal is to keep the professionals working with the ambulance services out there in the communities because the volunteers are getting burnt out.

Chairman Lee describes that this is merely filling a gap between the EMS and the clinic. The scope of practice is not defined in the pilot project because there is no scope of practice yet. It seems that the pilot project is ahead of the resolution and it is hopeful that this study can define what that is over the course of this session.

There is no further discussion.

Senator Anderson motions a Do Pass.

Senator Dever seconds.

Roll call votes: 5-0, Do Pass.

Senator Larson volunteers to carry Resolution to the floor.

Date: 1/14/13
Roll Call Vote #: 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 4002

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☑ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen. Anderson Seconded By Sen. Dever

Senators	Yes	No	Senator	Yes	No
Chariman Judy Lee	✓		Senator Tyler Axness	✓	
Vice Chairman Oley Larsen	✓				
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen. Larsen

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SCR 4002: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SCR 4002 was placed on the Eleventh order on the calendar.

2013 HOUSE HUMAN SERVICES

SCR 4002

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SCR 4002
March 26, 2013
Job #20521

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

A concurrent resolution directing the Legislative Management to study the feasibility and desirability of community paramedics in providing additional clinical and public health services in rural areas.

Minutes: *See Testimonies #1-2*

Chairman Weisz opened the hearing on SCR 4002.

June Herman: Regional Vice-President of the Heart Association stated support for the bill.

Rep. Laning: Is this recommending the expansion of capabilities?

Chairman Weisz: There is someone here that can answer that question.

Tim Wiedrich: Section Chief of the ND Department of Health's Emergency preparedness and Response Section: Testified in a neutral position and gave information. (See Testimony #1)

6:02
Chairman Weisz: Is there any issue with scope of practice or additional training that might be required?

Weidrich: We don't believe that we are expanding the scope of skills. We are placing them in a different environment and yes there will be additional training. There is a national curricular that has developed and it is being implemented. This is cutting edge stuff and multiple states have adopted it and there are many more behind this movement. If we move forward with the pilot process as it is engaged in the executive budget, it would be bringing a training program to provide additional training for EMS providers that would be functioning in this setting.

Chairman Weisz: In the Governor's budget it says a half time position. Would they be addressing a rural community?

Weidrich: We see benefit for both rural and urban. They are different benefits. In urban areas currently EMS systems when they are called usually end up transporting to a medical facility. This would provide some assistance and be able to screen out those transports so they don't necessarily have to incur those hospital expenses. In rural areas where services don't exist it would be about delivering those services.

OPPOSITION

9:08
Karen Macdonald: A registered Lobbyist with the ND Nurses Association testified in opposition of the bill. (See Testimony #2)

Chairman Weisz closed the hearing on SCR 4002.

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SCR 4002
March 27, 2013
Job #20552

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

A concurrent resolution directing Legislative Management to study the feasibility of community paramedics in providing additional clinical and public health services in rural areas.

Minutes:

Chairman Weisz: Let's look at 4002.

Rep. Porter: The national group who created the criteria of what and who the paramedic is; I'm on that board of directors. The premise behind community paramedic is the movement that happened in Arizona where people in rural communities had an ambulance service and a paramedic and nobody else. They did a pilot project that gave the paramedic more training in doing other things. This allows for a study to see if it fits in rural ND. Minnesota has adopted community paramedic and expanded their training levels and using them in rural Minnesota.

Chairman Weisz: I was disappointed in the Health Dept. because they were neutral. Dr. Dwelle talked to me one and half years ago and he is a huge supporter of the concept. I thought for sure the Health Dept. would support the study of it.

Rep. Silbernagel: How many paramedics are there in ND?

Rep. Porter: Maybe around 100. Most work in the urban areas.

Rep. Silbernagel: I think this is something we should pursue because in the rural areas you can be out there a long time without medical attention.

Chairman Weisz: One of the discussions I had with Dr. Dwelle was one of the real benefit potentials was you could put a paramedic in an area that you couldn't justify from the funding standpoint. But, if they can bill for the services beyond the emergency services then it makes the community able to afford that paramedic.

Rep. Porter: The prime example would be Steele. They have paramedics and no other health care there. If somebody needs a simple suture, they have to drive to Bismarck to get it.

Vice-Chair Hofstad: What kind of challenges do we have billing those services?

Chairman Weisz: There will be some.

Rep. Porter: From a third party reimbursement standpoint I think they would be supportive of the concept as they would see it saving them money. Keep in mind for example if a person needs sutures; as far as training goes, there wouldn't be much needed to get to this level for the paramedic. Most of the courses are around 300 hours with 150 being book and 150 working in an emergency department with a physician.

Rep. Anderson: How many states are doing it?

Chairman Weisz: Six or seven.

Rep. Porter: There are many states looking at it and a lot of movement in this direction. The only one I do know of is Minnesota.

Chairman Weisz: There are six or seven and in Canada.

Rep. Fehr: I move a Do Pass and placed on the Consent Calendar.

Rep. Silbernagel: Second.

VOICE VOTE: MOTION CARRIED

Bill Carrier: Rep. Silbernagel

Date: 3-27-13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 4002

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Fehr Seconded By Rep. Silbernagel

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment Rep. Silbernagel

If the vote is on an amendment, briefly indicate intent:

Place on Consent Calendar
Voice Vote Motion Carried

REPORT OF STANDING COMMITTEE

SCR 4002: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SCR 4002 was placed on the Tenth order on the calendar.

2013 TESTIMONY

SCR 4002

Attachment #1

Madame Chair, members of the committee:

For the record, my name is Sheila Sandness and I am a Senior Fiscal Analyst for the Legislative Council. I am here to present information on Senate Concurrent Resolution 4002 relating to a study of the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state. I appear neither for nor against the resolution, but just to provide information and answer any questions you may have.

The interim Health Services Committee recommends Senate Concurrent Resolution No. 4002 which provides for a Legislative Management 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 system.

The interim Health Services Committee received information 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 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. The committee learned stakeholders have been gathering information and are considering issues related to needs, certification, regulation, and reimbursement. The Health Services Committee's findings and recommendation regarding community paramedics can be found in the "Report of the North Dakota Legislative Management".

The executive recommendation includes $276,600 and 1 FTE position for the State Department of Health to implement a community paramedic/community health care worker pilot project, including funding of $141,600 for educational startup costs.

That concludes my testimony and I would be happy to answer any questions you may have.

Attachment #2

Testimony
Senate Concurrent Resolution 4002
Senate Human Services Committee
Monday, January 14, 2013; 11:30 a.m.
North Dakota Department of Health

Good morning, Chairwoman Lee and members of the Human Services Committee. I am Tim Wiedrich, Section Chief of the North Dakota Department of Health's Emergency Preparedness and Response Section. I am here to provide information regarding Senate Concurrent Resolution 4002.

The concept of community paramedics is to use portions of the Emergency Medical Services (EMS) workforce to address community health and medical needs that communities currently do not have the resources to address. The program would build on existing skill sets to deliver primary care services such as assessments, chronic disease management, blood draws, diagnostic cardiac monitoring, fall prevention, medication reconciliation and other services in a highly mobile environment. These services could be delivered in many environments such as homes, schools and places of employment where they are currently not available.

We believe a community paramedic program can create three major improvements in North Dakota while reducing health-care costs. Those improvements are as follows:

1. The provision of services in rural communities where no clinical services or hospitals currently exist. A community paramedic program in this environment will increase access to health care while reducing travel costs and clinical expenses.
2. Reduction in unnecessary and expensive visits to emergency departments. These savings would be achieved by providing a screening process by the EMS system, under medical direction, and the delivery of services in the field when it is safe and effective to do so.
3. Sustainment of the existing EMS system by creating revenue streams that are not exclusively tied to the transport of patients to or from medical facilities. Under the current system design, EMS providers have substantial periods of time in which they are not delivering services as they wait for the next emergency call and revenue is only generated when patents are transported. The community paramedic

concept would allow EMS services to provide revenue generating non-emergency care in the community while maintaining the capability to respond quickly to emergency calls.

A community paramedic model can be beneficial because it promotes coordinated and integrated care by the EMS system with physicians, nurse practitioners and physician assistants, hospitals, home health agencies, long-term care facilities, and public health departments. This model creates a team approach to health care from the home through the entire health care continuum.

The governor's executive budget includes an appropriation and a half time position to conduct a pilot community paramedic program. We would look forward to working with legislative management on this study as the pilot project is implemented.

We have attached a fact sheet that provides additional information about community paramedic programs. I would be happy to answer any questions you may have.

NORTH DAKOTA DEPARTMENT of HEALTH

COMMUNITY PARAMEDIC

Community Paramedic Fact Sheet

Problem Statement:

- Access to health care, particularly primary care services, is a growing concern. Primary care providers are in short supply, and the uninsured population is on the rise.
- Uninsured patients are less likely to seek out preventive care services and are more likely to go to the emergency room for non-urgent care, increasing the cost of health care.
- In rural areas, the problem has increased because of a higher rate of uninsured and a shortage of health-care providers.

Opportunity:

- To address the decrease in access to primary care services, it is necessary to evaluate current resources within communities and explore innovative solutions. The Community Paramedic model is an innovative solution that provides essential primary care services for vulnerable populations.
- Paramedics have the training, expertise and scope of practice to provide primary care services such as assessments, blood draws, diagnostic cardiac monitoring, fall prevention, and medication reconciliation. They also have the experience of taking health care into the home.
- EMS personnel are already integrated throughout the health-care system, allowing them to easily provide primary care services within their scope of practice.
- States such as Minnesota, Texas, Colorado, Hawaii, Arizona and North Carolina have community paramedic programs already running. A dozen other states are in the process of starting one.

What the Community Paramedic model offers:

- Enhanced utilization of a health-care resource under the current scope of practice.
- Coordinated and integrated care with physician's offices, hospitals, home health agencies, long-term care facilities, and public health departments.

The Community Paramedic model will NOT:

- Replace current health-care systems or positions.
- Change the current defined scope of practice of EMS personnel.
- Remove patient populations from health-care providers.
- Decrease the level of care provided.

-Over-

Community Paramedic Fact Sheet (cont.)

Statistics

Primary care shortage

- In January 2012, all but one county in N.D. was completely or partially designated as a Health Professional Shortage Area. [1]
- In July 2012, all but one county in N.D. was completely or partially designated as a Medically Underserved Area or Population. [2]
- According to the U.S. Census, three of the top 10 micro areas with the greatest growth from April 1, 2010, to July 1, 2011, were in western North Dakota.[3]

Uninsured/Underinsured rates

- In 2010, 6.5 percent (32,000) of North Dakota residents reportedly did not see a doctor in the previous 12 months due to costs.[4]
- During 2009/2010, 12 percent of North Dakota residents were reportedly uninsured.[5]

Readmission rates

- Nationwide, preventable readmissions may be costing up to $12 billion dollars annually in the Medicare program alone.[6]

Cost of health care in Emergency Departments

- The charges in an emergency department for minor, non-urgent problems may be two to five times higher than charges for a typical private physician office visit.[7]
- According to Johns Hopkins University, between 1997 and 2007, 13 percent of trauma patients returned to the emergency room within a month of discharge for routine follow-up care such as dressing changes.[8]
- From 1/3 to 3/4 of all emergency department visits are avoidable depending on patient demographics and emergency department location.[7]

Preventive services

- In 2009, 73 percent of North Dakota deaths were caused by chronic health issues.[9]

1. *UND Center for Rural Health ND HPSA Map Website:* http://ruralhealth.und.edu/maps/mapfiles/hpsa.png
2. *Health Resources and Services Administration, database tool,* http://muafind.hrsa.gov/index.aspx.
3. http://www.census.gov/newsroom/releases/archives/population/cb12-55.html
4. *Henry J. Kaiser Family Foundation:* http://www.statehealthfacts.org/profileind.jsp?rgn=36&cat=8&ind=747
5. *Ibid:* http://www.statehealthfacts.org/profileind.jsp?ind=125&cat=3&rgn=36
6. *Medicare Payment Advisory Commission (MedPAC), June 2005:83-103*
7. *The Impact of Community Health Centers & Community-Affiliated Health Plans on Emergency Department Use, National Association of Community Health Centers, April 2007* http://www.nachc.com/client//ED%20Util%20Reduction%20NACHC-ACAP%20Report%204.07.pdf
8. Johns Hopkins press release, August 24, 2011.
9. *http://www.ndhealth.gov/chronicdisease/Publications/2010_CD_Status%20Report.pdf*

Nursing Facility Workforce

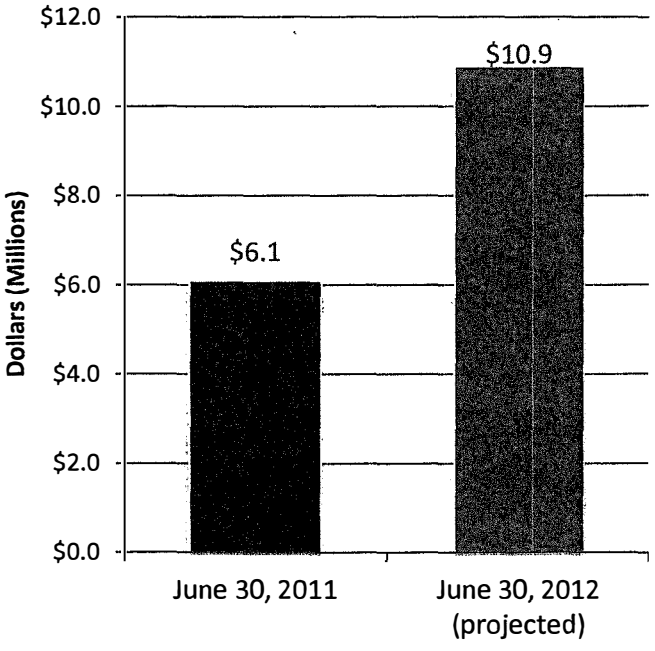
Attachment #3

Nursing Facility Workforce

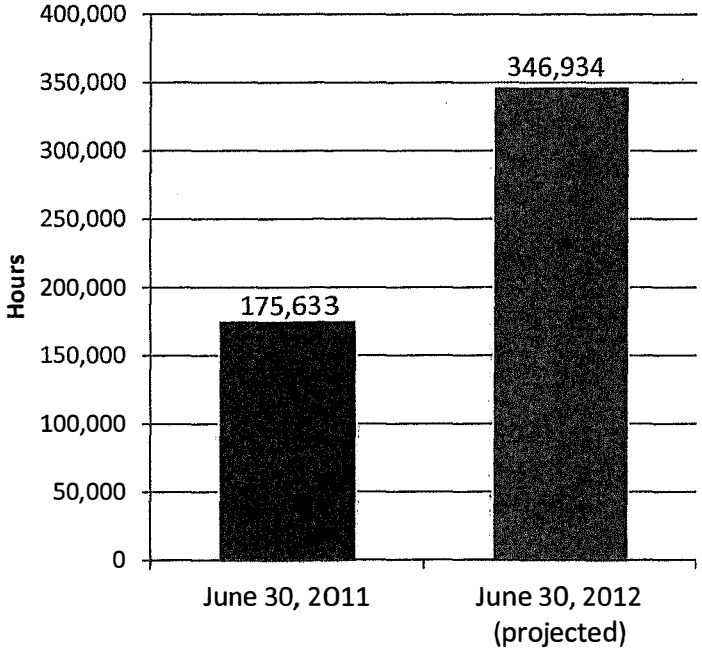
- Top issue facing nursing facilities is staffing.
- Number of individuals employed in 68 nursing facilities was 9,267. Based upon this ratio, total people employed by 83 nursing facilities are estimated to be 11,311.
- July 1, 2012, sixty-three nursing facilities reported 751 vacant positions.
- Nine of sixty-six reporting nursing facilities stopped admissions in 2012 because of a lack of staff.
- Sixty-six percent of nursing facilities, 2 out of 3 facilities, used contract agency staff in 2012.
- Contract nursing hours increased 98% over the past twelve months.
- The 2012 average salary increase provided was 2.9%, however one-third of nursing facilities also provided an extra enhancement to retain their employees. Enhancements were as high as $5 per hour to 20% increases.

Contract Nursing

Dollars Spent

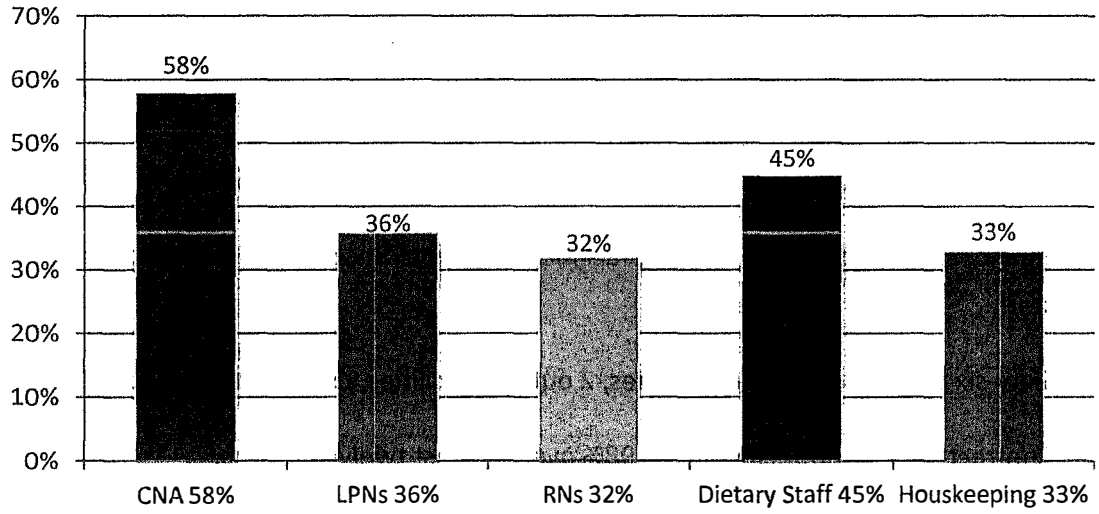


Contracted Hours

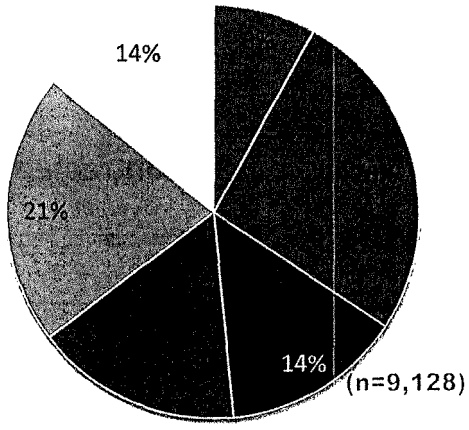


Nursing Facility Workforce (continued)

2012 Staff Turnover



Age of Nursing Facility Workforce



- 19 & Under 8%
- 20-29 26%
- 30-39 14%
- 40-49 16%
- 50-59 21%
- 60 & Over 14%

- Turnover and age of our workforce will create an unprecedented demand for employees in the next 10 years.
- The youngest employee is 14 and the oldest employee is 99.
- Over one-third of our workforce is age 50 and older.
- North Dakota will need 1,880 additional nurses by 2018.

North Dakota Long Term Care Association
1900 N 11th St (701) 222.0660
Bismarck, ND 58501 www.ndltca.org

#1

Testimony
Senate Concurrent Resolution 4002
House Human Services Committee
Tuesday, March 26, 2013; 3:00 p.m.
North Dakota Department of Health

Good afternoon, Chairman Weisz and members of the Human Services Committee. I am Tim Wiedrich, Section Chief of the North Dakota Department of Health's Emergency Preparedness and Response Section. I am here to provide information regarding Senate Concurrent Resolution 4002.

The concept of community paramedics is to use portions of the Emergency Medical Services (EMS) workforce to address community health and medical needs that communities currently do not have the resources to address. The program would build on existing skill sets to deliver primary care services such as assessments, chronic disease management, blood draws, diagnostic cardiac monitoring, fall prevention, medication reconciliation and other services in a highly mobile environment. These services could be delivered in many environments such as homes, schools and places of employment where they are currently not available.

We believe a community paramedic program can create three major improvements in North Dakota while reducing health-care costs. Those improvements are as follows:

1. The provision of services in rural communities where no clinical services or hospitals currently exist. A community paramedic program in this environment will increase access to health care while reducing travel costs and clinical expenses.
2. Reduction in unnecessary and expensive visits to emergency departments. These savings would be achieved by providing a screening process by the EMS system, under medical direction, and the delivery of services in the field when it is safe and effective to do so.
3. Sustainment of the existing EMS system by creating revenue streams that are not exclusively tied to the transport of patients to or from medical facilities. Under the current system design, EMS providers have substantial periods of time in which they are not delivering services as they wait for the next emergency call and revenue is only generated when patents are transported. The community paramedic

concept would allow EMS services to provide revenue generating non-emergency care in the community while maintaining the capability to respond quickly to emergency calls.

A community paramedic model can be beneficial because it promotes coordinated and integrated care by the EMS system with physicians, nurse practitioners and physician assistants, hospitals, home health agencies, long-term care facilities, and public health departments. This model creates a team approach to health care from the home through the entire health care continuum.

The governor's executive budget includes an appropriation and a half time position to conduct a pilot community paramedic program. In addition, our federal grantors are now encouraging engagement with community paramedic programs. We would look forward to working with legislative management on this study as the pilot project is implemented.

We have attached a fact sheet that provides additional information about community paramedic programs. I would be happy to answer any questions you may have.

NORTH DAKOTA
DEPARTMENT of HEALTH

COMMUNITY
PARAMEDIC

Community Paramedic Fact Sheet

Problem Statement:

- Access to health care, particularly primary care services, is a growing concern. Primary care providers are in short supply, and the uninsured population is on the rise.
- Uninsured patients are less likely to seek out preventive care services and are more likely to go to the emergency room for non-urgent care, increasing the cost of health care.
- In rural areas, the problem has increased because of a higher rate of uninsured and a shortage of health-care providers.

Opportunity:

- To address the decrease in access to primary care services, it is necessary to evaluate current resources within communities and explore innovative solutions. The Community Paramedic model is an innovative solution that provides essential primary care services for vulnerable populations.
- Paramedics have the training, expertise and scope of practice to provide primary care services such as assessments, blood draws, diagnostic cardiac monitoring, fall prevention, and medication reconciliation. They also have the experience of taking health care into the home.
- EMS personnel are already integrated throughout the health-care system, allowing them to easily provide primary care services within their scope of practice.
- States such as Minnesota, Texas, Colorado, Hawaii, Arizona and North Carolina have community paramedic programs already running. A dozen other states are in the process of starting one.

What the Community Paramedic model offers:

- Enhanced utilization of a health-care resource under the current scope of practice.
- Coordinated and integrated care with physician's offices, hospitals, home health agencies, long-term care facilities, and public health departments.

The Community Paramedic model will NOT:

- Replace current health-care systems or positions.
- Change the current defined scope of practice of EMS personnel.
- Remove patient populations from health-care providers.
- Decrease the level of care provided.

-Over-

Community Paramedic Fact Sheet (cont.)

Statistics

Primary care shortage

- In January 2012, all but one county in N.D. was completely or partially designated as a Health Professional Shortage Area. [1]
- In July 2012, all but one county in N.D. was completely or partially designated as a Medically Underserved Area or Population. [2]
- According to the U.S. Census, three of the top 10 micro areas with the greatest growth from April 1, 2010, to July 1, 2011, were in western North Dakota.[3]

Uninsured/Underinsured rates

- In 2010, 6.5 percent (32,000) of North Dakota residents reportedly did not see a doctor in the previous 12 months due to costs.[4]
- During 2009/2010, 12 percent of North Dakota residents were reportedly uninsured.[5]

Readmission rates

- Nationwide, preventable readmissions may be costing up to $12 billion dollars annually in the Medicare program alone.[6]

Cost of health care in Emergency Departments

- The charges in an emergency department for minor, non-urgent problems may be two to five times higher than charges for a typical private physician office visit.[7]
- According to Johns Hopkins University, between 1997 and 2007, 13 percent of trauma patients returned to the emergency room within a month of discharge for routine follow-up care such as dressing changes.[8]
- From 1/3 to 3/4 of all emergency department visits are avoidable depending on patient demographics and emergency department location.[7]

Preventive services

- In 2009, 73 percent of North Dakota deaths were caused by chronic health issues.[9]

1. *UND Center for Rural Health ND HPSA Map Website:* http://ruralhealth.und.edu/maps/mapfiles/hpsa.png
2. *Health Resources and Services Administration, database tool,* http://muafind.hrsa.gov/index.aspx.
3. http://www.census.gov/newsroom/releases/archives/population/cb12-55.html
4. *Henry J. Kaiser Family Foundation:* http://www.statehealthfacts.org/profileind.jsp?rgn=36&cat=8&ind=747
5. *Ibid:* http://www.statehealthfacts.org/profileind.jsp?ind=125&cat=3&rgn=36
6. *Medicare Payment Advisory Commission (MedPAC), June 2005:83-103*
7. *The Impact of Community Health Centers & Community-Affiliated Health Plans on Emergency Department Use, National Association of Community Health Centers, April 2007* http://www.nachc.com/client//ED%20Util%20Reduction%20NACHC-ACAP%20Report%204.07.pdf
8. Johns Hopkins press release, August 24, 2011.
9. *http://www.ndhealth.gov/chronicdisease/Publications/2010_CD_Status%20Report.pdf*

#2

March 26, 2013

Chairman Weisz, Members of the House Human Services Committee

My name is Karen Macdonald, I am a Registered Lobbyist with the North Dakota Nurses Association, a Nurse Practitioner, and have practiced as both a nurse practitioner and a public health nurse in rural areas in North Dakota and South Dakota. I am testifying in opposition to HCR 4002, as it seeks to expand the services of Emergency Medical Technicians to provide **primary** care services at a local community level. Primary care services are not emergency services, in fact are directed towards efforts to assist people to maintain their healthy status through education, and direction in requirements for health living. As used in this concurrent resolution, primary care services are defined as "clinical and public health" services, and direct an expectation of third-party reimbursement.

The actual definition of primary care by WHO is as follows:

> **Primary Health Care as defined by the World Health Organization in 1978 is:**
>
> **essential health care; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination (WHO & UNICEF, 1978).**

In North Dakota, primary care is defined as anything that is delivered outside of the major tertiary medical centers. But as used in medical writings, it is a setting or a set of attributes of medical care.

> *Defining Primary Care: An Interim Report* (IOM, 1994b).
>
> **A *level of care or setting***—an entry point to a system that includes secondary care (by community hospitals) and tertiary care (by medical centers and teaching hospitals) (Fry, 1980); ambulatory versus inpatient care;
>
> **A *set of attributes***, as in the 1978 IOM definition—care that is accessible, comprehensive, coordinated, continuous, and accountable—or as defined by Starfield (1992)—care that is characterized by first contact, accessibility, longitudinality, and comprehensiveness

Current third-party reimbursement (through Medicaid, Medicare and commercial insurance) requires a medical diagnosis according to ICD-9 (soon ICD-10) and/or treatment according to a recognized CPT code for reimbursement. There is a very rigid set of criteria that must be met for skilled nursing services in the home, such as dressing changes, medication monitoring. How easily will reimbursement be achieved for this service? Apparently the reimbursement that is being sought is envisioned as offsetting the cost of providing emergency medical services. I looked at the Health Department proposed budget for 2013-2014 biennium and the department already is penciled in for 7.34 million dollars in grants to the various ems services. Will the

reimbursement dollars be used to offset these public dollars? It would seem that if the public dollars are being used to subsidize the ems services, the ems personnel could provide the service envisioned within the community paramedic role without having to seek reimbursement.

Excerpt from Health Department Budget Bill (SB 2004):

> 55. Increases funding for rural emergency medical services grants to provide a total of $7.34 million, of which $1.25 million is from the insurance tax distribution fund
> $2,350,000 $2,350,000
> 56. Decrease funding for emergency medical services grants to transfer funding for an emergency medical services grants manager
> ($200,000) ($200,000)
> 57. Increases the salaries and wages line item ($139,096) and the operating expenses line item ($60,904) for an emergency medical services grants manager

This is in addition to the funding for the pilot project (1FTE to implement a community paramedic/community health care worker pilot project including funding for educational startup costs. ($276,000 – SB 2004)

I have prepared the following information as a report to be published in the North Dakota Nurses Association paper **The Prairie Rose.**

What are paramedics?

According to the home page of Community Paramedics (http://www.communityparamedic.org/) "This is a branch of primary care patterned after the physician assessment and treatment model." The movement started many years ago in Canada when a physician in a rural area retired and the only health care personnel in the area were emergency medical technicians. The Community Paramedic Program is built on the Rural and Frontier EMS Agenda of the Future—a 2004 report that describes an optimal future for rural EMS, as well as the changes required to achieve that vision. (http://www.emsworld.com/article/10324818/rural-ems-agenda-for-the-future). The community paramedic role is found in five U.S. states, Canada, and Australia. The community paramedic is described as an extension of the primary care provider to provide care to patients without access to primary care and would not replace specialized services available in a home health care office. The community paramedic would function under the supervision of a physician, to provide quality of care consistent within a clinic setting.

According to EMS World in an article titled "Minnesota Gets Its Community Paramedic Program" (http://www.emsworld.com/article/10318789/minnesota-gets-its-community-paramedics) the curriculum will require 120 hours of additional training and will include minor suturing, vaccinations, drawing blood, checking children's ears for infections, and recognizing mental health and chemical dependency issues in order to route those patients to proper care. Potential students are identified as current EMS providers with a minimum of one year experience, but might also include individuals looking for a career change. The intent is to eventually achieve third-party reimbursement to enable EMS programs in rural and medically

underserved areas to be financially sustainable. Since Minnesota authorized establishment of community paramedics Hennepin Technical College in Saint Cloud, MN has developed and implemented a defined curriculum.

My Concerns:

In discussion with individuals at the North Dakota Health Department, there are many areas in rural North Dakota where individuals with health care problems have no access to health care providers. But with the EMS system in North Dakota, emergency personnel are within reach of these individuals in need of care. It might be a dressing change, a monitoring of medications, and could be problem-solving with the individual to determine the best course of action. Doesn't this sound like what nurses do? Is this something that can be learned in 120 hours of instruction?

Will it be comprehensive, coordinated, continuous, and will there be accountability? - to paraphrase the definition above of primary care from the IOM study.

A description of how paramedics in Wisconsin would function in this role is found at the Baraboo Community Paramedics website (www.communityparamedics.com) . "Patients will be referred to CP through the discharge process and the patient's treating physician, physician assistant, or nurse practitioner. The CP functions as an extension of primary health care by providing services to the community through physician referrals. The CP delivers primary care through home visits with emphasis on injury and wellness prevention, medical history and health assessment, medication reconciliation, and evaluation of chief complaints that incorporate physician-directed treatment plans and protocols." Now this really sounds like nursing.

How would this relate to currently practicing licensed nurses?

Current state law does not provide any intersection between emergency medical providers and licensed nurses. Twenty some years ago, EMT's wanted to come into hospitals and do "tasks" – I remember one saying "I can start your IV's, put in your catheters" but because laws and regulations required that those tasks be performed under the direction of the licensed nurse, and at that time EMT's felt that their authority to practice stemmed from licensed physicians, after much discussion, the concept was never implemented. Organized nursing needs to be fully aware of the implications of the community paramedic program as the funding authorization and request for legislative study moves through the current session. There is every indication that regardless of whether or not this concurrent resolution is chosen for study by the Legislative Management, the 2013-14 biennium will contain dollars to implement the community paramedic program. Are we ready for this?

Karen Macdonald, NDNA Registered Lobbyist