15.0263.04000

FISCAL NOTE
Requested by Legislative Council
04/03/2015

Amendment to: SB 2043

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$(932,574)		$(1,306,870)
Expenditures			$(932,574)	$(932,574)	$(1,306,870)	$(1,306,870)
Appropriations			$(932,574)	$(932,574)	$(1,306,870)	$(1,306,870)

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB2043 directs the Department to adopt rules governing payments to licensed paramedics and EMT's for health-related services provided to recipients of medical assistance. The Department may negotiate additional rebates from drug manufactures and may join a multistate supplemental drug rebate pool.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 directs the department to adopt rules and provide payments to licensed community paramedics and emergency medical technicians for providing health-related services to recipients of medical assistance. Any care provided by a licensed community paramedics or emergency medical technicians must be supervised by a physician or advanced practice registered nurse. The department estimates that there are 100 potential recipients who would benefit from these services. The fiscal note assumes a July 1, 2016 implementation to allow adequate time for the Department to adopt rules. 15-17 biennium expenditures will increase by $36,000 of which $18,000 is General Fund and $18,000 is Federal Funds.

Section 2 allows the department to negotiate additional rebates from drug manufacturers to supplement the rebates required by federal law governing the medical assistance program. Additionally, the department may join a multistate supplemental drug rebate pool. The fiscal note assumes a January 1, 2016 implementation resulting in a supplemental rebate increase equal to 3% of the pre-rebate pharmacy expenditures. The 15-17 biennium expenditures are estimated to decrease by ($1,901,148) of which ($950,574) is General Fund and ($950,574) are Federal Funds.

The net Fiscal impact for the 15-17 biennium is an expenditure decrease of ($1,865,148)of which ($932,574) is General Fund and ($932,574) are Federal Funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

      The Department will reduce the net federal Medicaid funding it receives by increasing the amount of drug rebates it collects, thus reducing revenue by ($932,574) for the 15-17 biennium and ($1,306,870) for the 17-19 biennium.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

      The net estimated expenditures under the Medicaid grants line item for the 15-17 biennium would be reduce by ($1,865,148) of which, ($932,574) is General Fund and ($932,574) is Federal Funds. In the 17-19 biennium, estimated expenditures would be ($2,613,740) of which, ($1,306,870) is General Fund and ($1,306,870) is Federal Funds.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

      The Departments appropriation in SB2012 may be decreased for the 15-17 biennium by ($1,865,148) of which, ($932,574) is General Fund and ($932,574) is Federal Funds. The Department's appropriation need will decrease for the 17-19 biennium by ($2,613,740) of which, ($1,306,870) is General Fund and ($1,306,870) is Federal Funds.

Name: Debra A. McDermott

Agency: Human Services

Telephone: 701-328-3695

Date Prepared: 04/07/2015

15.0263.03000

FISCAL NOTE
Requested by Legislative Council
01/21/2015

Amendment to: SB 2043

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$18,000		$38,190
Expenditures			$18,000	$18,000	$38,190	$38,190
Appropriations			$18,000	$18,000	$38,190	$38,190

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB2043 directs the Department of Human Services to adopt rules governing payments to licensed community paramedics and emergency medical technicians for health-related services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 directs the department to adopt rules and provide payments to licensed community paramedics and emergency medical technicians for providing health-related services to recipients of medical assistance. Any care provided by a licensed community paramedics or emergency medical technicians must be supervised by a physician or advanced practice registered nurse. The department estimates that there are 100 potential recipients who would benefit from these services. The fiscal note assumes a July 1, 2016 implementation to allow adequate time for the Department to adopt rules. 15-17 biennium expenditures will increase by $36,000 of which $18,000 is General Fund and $18,000 is Federal Funds. 17-19 biennium expenditures will increase by $76,380 of which $38,190 is General Fund and $38,190 is Federal Funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The Department will be able to access federal Medicaid funding of $18,000 for the 15-17 biennium and $38,190 for the 17-19 biennium.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

With an effective date of July 1, 2016, estimated expenditures under the Medicaid grants line item for the 15-17 biennium would total $36,000 of which, $18,000 is General Fund and $18,000 is Federal Funds. In the 17-19 biennium, estimated expenditures would be $76,380 of which, $38,190 is General Fund and $38,190 is Federal Funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation increase for the 15-17 biennium of $36,000, of which, $18,000 is General Fund and $18,000 is Federal Funds. The Department will need an appropriation increase for the 17-19 biennium of $76,380, of which, $38,190 is General Fund and $38,190 is Federal Funds.

Name: Debra A. McDermott

Agency: Human Services

Telephone: 701-328-3695

Date Prepared: 01/12/2015

15.0263.02000

FISCAL NOTE
Requested by Legislative Council
12/19/2014

Bill/Resolution No.: SB 2043

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$18,000		$38,190
Expenditures			$18,000	$18,000	$38,190	$38,190
Appropriations			$18,000	$18,000	$38,190	$38,190

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB2043 directs the Department of Human Services to adopt rules entitling licensed community paramedics to payment for health-related services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 directs the department to adopt rules and provide payments to licensed community paramedics for providing health-related services to recipients of medical assistance. The department estimates that there are 100 potential recipients who would benefit from these services. The fiscal note assumes a July 1, 2016 implementation to allow adequate time for the Department to adopt rules. 15-17 biennium expenditures will increase by $36,000 of which $18,000 is General Fund and $18,000 is Federal Funds. 17-19 biennium expenditures will increase by $76,380 of which $38,190 is General Fund and $38,190 is Federal Funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

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The Department will be able to access federal Medicaid funding of $18,000 for the 15-17 biennium and $38,190 for the 17-19 biennium.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

With an effective date of July 1, 2016, estimated expenditures under the Medicaid grants line item for the 15-17 biennium would total $36,000 of which, $18,000 is General Fund and $18,000 is Federal Funds. In the 17-19 biennium, estimated expenditures would be $76,380 of which, $38,190 is General Fund and $38,190 is Federal Funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation increase for the 15-17 biennium of $36,000, of which, $18,000 is General Fund and $18,000 is Federal Funds. The Department will need an appropriation increase for the 17-19 biennium of $76,380, of which, $38,190 is General Fund and $38,190 is Federal Funds.

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Date Prepared: 01/12/2015

2015 SENATE HUMAN SERVICES

SB 2043

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2043
1/13/2015
J# 21868

☐ Subcommittee
☐ Conference Committee

Donald Mueller

Explanation or reason or introduction of bill/resolution:

Relating to medical assistance coverage for the services of licensed community paramedics.

Minutes:

Attach #1: Testimony by Sheila Sandness
Attach #2: Testimony by Mike Reitan
Attach #3: Testimony by June Herman
Attach #4: Testimony by Dr. Patricia Moulton
Attach #5: ND Center for Licensing, Policy Brief for Community Paramedic Pilot Study Recommendations
Attach #6: Email from Dr. Patricia Moulton

Fiscal note is in the file

Shiela Sandness Testimony (attach #1), Fiscal Analyst for Legislative Council, presented information on SB 2043, neither for nor against. Testimony ends (3:45)

Senator Warner inquired about licensed paramedics, which he understands to be the individual who performs the service, does the money flow to the individual as an independent contractor or to the service which would be paid in their salary?

Ms. Sandness responded that in the pilot project, they were performing services for an entity, but they would need to be registered as a provider to receive payment for services.

Senator Warner asked in regards to the fiscal note, is there an offset in the budget where these people who are receiving medical assistance have received the same services in another setting where we are deducting the cost of transportation? Are they receiving the services more efficiently to the department than what the fiscal note reflects where the number would be smaller?

Ms. Sandness responded that the Department of Human Services would have to discuss this.

Senator Dever asked where community paramedics licensed? Department of Health?

Ms. Sandness responded yes, the Department of Health, they are licensed paramedics.

Senator Dever asked if they were reimbursed for these services through private insurance?

Ms. Sandness answered not currently, that would be something that would have to be worked out.

Chairman Judy Lee indicated that more information will follow from Mr. Tom Nehring from the Department of Health.

End of Shiela Sandness Testimony and Discussion.

Mike Reitan testimony (attach #2), Chief of Police, West Fargo Police Department, spoke in favor of SB 2043. (testimony ends 8:50).

Mr. Reitan provided information whether there will be a cost savings. There are several people in the community who routinely call an ambulance, which required a full response of the ambulance crew, including possible transportation to hospital, are now being served by a paramedic who comes to the home and addresses the issue. This lower the level which results in a reduction of cost to the services and to State of ND and insurance.

Chairman Judy Lee indicated that the community paramedic in the Fargo area is hired by FM Ambulance which is a paid service which is connected with Sanford as well, but don't get reimbursed for a 9.1.1. call that isn't appropriate purpose. By having these community paramedics involved, one who gets called every 36 hours to the ambulance service, and there may be other issues that need attention, but not 9.1.1. level calls, the savings to the ambulance services are there, and ambulance resources could be utilized where needs are more urgent.

Mr. Reitan indicated that is correct, and the number of calls that come in. There would be substantial savings if this program was implemented. He gave example of his father who would be a client under these services, being treated at home and free the ambulance service up for a different emergency.

Chairman Judy Lee indicated that a community of care program in Casselton and Arthur which organizes volunteers to assist people who do need a drive, a model that can be duplicated across the state.

Senator Warner talked about appropriate response, is there a systematic way of coordinating social workers, mental health professionals, to determine the new normative behavior rather than making everything an emergency

Mr. Reitan indicated they are in an infancy in that evolution to that type of system. When someone calls 9.1.1 today, they get a full response today. At that time of arrival, it is the opportunity to conduct triage the situation, and begin de-escalating freeing back resources to the community so if other emergencies arise they can address those emergencies. When this occurs, they contact Cass County Social Services adult protection and notifying Southeast Human Service Center as the person may not end up being transported or referred to that agency, but they build a history so if, or when they are referred, the agency

can go back to see all the contacts that were made. This is an evolution of how they provide care in the community.

Chairman Judy Lee indicated that the mobile access unit from Human Service Center should have a place in this as well to be available and accessible for police departments and others who have someone who needs more attention than what the community paramedic can provide.

Mr. Reitan indicated that the community paramedic and crisis response teams are in the middle of this; the client needs some level of service but they don't need the high end level of service, so the community paramedic program can deal with the crisis of response.

End of Mr. Reitan Testimony and discussion.

Tom Nehring, Department of Health, director of emergency services and trauma, testified (no prepared testimony) IN FAVOR of SB 2043. (14:50)

Mr. Nehring provided overview of Community paramedics, a concept that is not germane to North Dakota but across the nation. There are 2 models that they site, (1) an urban model, based on cost savings to the health care industry the community paramedics go out to the site or home or frequent flyers. The frequent flyers are the top 10 callers. In Fargo, they average 18 ambulance runs per month, and 18 emergency department visits per month, so this is millions of dollars in resources for someone who could be taken care of at home; (2) a rural model, where the gaps exists in North Dakota. If the service is available through home health, hospice, public health, then they don't see the role of the community paramedics helping in that particular community. In rural areas, community paramedics are the local EMTs and community health workers. Someone who can go into the patients home, whether post surgical, chronic disease, special needs, whatever the case may be, these are providers paid at a significant lower level than the what the other services are available, and as a result of that, decrease hospitalizations and health care dollars for that individual.

Chairman Judy Lee asked to explain where this fits in with the licensing process

Mr. Nehring indicated that at the start of this, it would change the scope of practice of paramedics. It really does not. It does change the environment that they work in. In this case, especially rural areas, the current workforce who exist that has a lot of down time will be able to do the home visits, thereby bring value to that. There is no increase scope; we'll not be having them do complicated procedures, but will do the services within their scope of practice. As a result of that, they are licensed by the Division of emergency services and trauma, as are all levels of emergency providers within North Dakota. We license them, we establish the scope of responsibilities and work. We have to have licensed providers to receive reimbursement; we will be looking at a health care team, which may include a provider, physician, nurse practitioner being the captain of that ship, and payment going through that mechanism rather than community paramedics themselves being recipient of individual dollars. Working with Medicaid (Julie Schwab) including the basic support aspect of this, commonly called a community health worker, it being an EMT, and also working with the NDSU/UND masters of public health program.

Chairman Judy Lee discussed it being a joint with NDSU and UND, first program of collaboration and both deserve credit.

Senator Warner indicated that both of his parents benefited from hospice, 100 mile trip to his farm, being chronic care, not acute care. Is there any discussion about cross training people resulting in mid-level practitioners who may help with various services?

Mr. Nehring indicated that is specifically what this is intended to do. Hospice and Home Health Care are handcuffed because on distance (100 miles), the financial incentive is not there for them to travel long distances, so if we have trained people within those communities that can do the home visits, that's one of the areas they are focused on, including hospice.

Senator Dever asked to explain what happens when a frequent flyer calls 9.1.1? Can the dispatcher able to ascertain what level of response is needed?

Mr. Nehring indicated that when 9.1.1 response, if it is one of the frequent flyer who doesn't need to go to emergency services, the paramedic who responds can discern that. They can triage the situation, call the community paramedic who comes in, if they can't handle, they can make a referral to one of the agencies, such as mental health, social services, etc, so it is a tiered system. Emergency still exists, the ambulance still goes out, makes appropriate assessment, not charged for that ambulance run, call community paramedic, and can respond for the appropriate treatment.

Senator Dever indicated that the first responder would likely be police officer, then depending on the location next would be fire department, than ambulance. Would they still all respond and then deescalate it?

Mr. Nehring answered yes, that they do not want to change the emergency response, because they cannot rely on good information on what they are going to see when on the scene. They don't want to change the emergency response, but perhaps in the future. Once the medical people arrive on the scene and they determine that it is not an emergency situation, the community paramedic can be called and respond.

End testimony of Mr. Nehring (27:02)

Mr. Ken Reed, coordinator for the community paramedic program for the division of emergency services and trauma, provided oral testimony IN FAVOR of SB 2043.

Mr. Reed indicated that there are a number of demonstration projects in the pilot that are in various stages of implementation: 2 in Fargo by Essentia Health, and 1 FM ambulance through Sanford. Essentia Health is the only full operating program, and has seen 107 patients thus far, and have been able to demonstrate a number of diversions from emergency room visits, referral processes back into their social and mental health components, and demonstrate a reduced readmission rate in several critical areas. FM ambulance program is still in development, two have completed the training and clinical requirements and 4 others that are working toward those requirements, at which time they

will implement. The FM program is unique in that they will only work with people that are identified within their system. They will have dispatch criteria, where those frequent flyers based on phone triage may just send the community paramedic rather than full emergency response. The other pilot program is in partial implementation. One of the prime areas was to include a waiver from the Centers of Medicare and Medicaid (CMS), as many of the critical hospital ambulance services are not reimbursed at cost as are the hospital as to what is due to the 35 mile rule for cost reimbursement but instead must be reimbursed for fee-for-service; waiver was supposed to be determined in July 2014 that would have granted cost reimbursement based upon the basis of using community paramedics. CMS is now 7 months into the process and have not responded yet. The 3 community paramedics now support their hospice program; one hospice nurse covers a 5 county region, so when she is off duty, the community paramedics are now taking the hospice call as well as seeing the patients. To date, they have seen a total of 17 hospice patients over 65 visits, where if the community paramedics had not been available, they would have dis-enrolled from hospice. The other programs are Billings County operating under a public health unit in Dickinson, operating under a private grant, personnel are still completing their training and hope to be implemented this spring. Bowman dropped from the program. Carrington health center was approved program but have as yet to enroll anyone in the community paramedic program. They initially contacted all the ambulance providers in the state that employ paramedics asking them to participate and to submit a proposal; they received the 5 proposals in whole. Many of these agencies are overwhelmed trying to provide basic emergency services; also no specific reimbursement available to cover costs of training and equipment.

Chairman Judy Lee asked where the training is occurring?

Mr. Reed indicated in Minneapolis at the Hennepin Technical College, program follows a national consensus curriculum, allows for distance training. Looking at in state training resource at Dakota College in Bottineau and FM Ambulance training through their affiliation at Wahpeton.

Senator Dever asked how does private insurance looks at this?

Mr. Reed indicated that currently there are no third-party reimbursement for these services, either through the federal programs or through the private insurers. Part of this is because of the infancy of the program and that even in Minnesota which are a number of years ahead of us have only secured only Medicaid and BCBS for reimbursement for their community paramedic services. Medicare is the number one consumer of these services, and yet at this point, because it is ill defined, CMS will ask what specific services do they do, and the answer is "it depends" on community gaps and services that the community paramedic can do assist with the other health care components to do. CMS has a problem defining the fee-for-service based on the question of what they are providing. Reimbursement likely will be looked at as a value-added service and compensation will come from alignment with a health care delivery entity rather than individual fee for service requests.

Senator Dever asked if we need definition for Medicaid for this bill? Mr. Dever indicated the department will do this through rules unless there is a need for further direction.

Mr. Reed answered that the intent was to allow as much as possible through procedural interaction with the Department of Human Services and being open ended versus specifically defining, and then adapt versus fees for services.

Chairman Judy Lee asked if it would be reasonable to have some latitude since there are two big departments (health and human services), for collaboration.

Mr. Reed responded, that is correct. This is one method of financing that the state controls for healthcare regarding what medicare and BCBS and other payers will pay or not. Once Minnesota Medicaid recognized this as a service and provided compensation, this provided momentum for other providers to recognize and jump on the band wagon.

V. Chairman Oley Larsen discussed the education perspective, and asked about tribal college's involvement?

Mr. Reed indicated that they wanted the program to be conducted by someone who is already doing medical medical education and who has the expertise and the affiliations to offer clinical preceptorships for the students and who has familiarity to paramedics, trying to build on top of that skill and education, so the logical is the ones who have medical instruction programs, nursing programs, and have opened it up to anybody that have interest. Not wanting to enourage everyone to build their own curriculum.

Chairman Judy Lee indicated that this may evolve.

End of Mr. Reed testimony.

Ms. June Herman testified IN FAVOR of SB 2043. (attach #3) (38:30 end)
Dickinson area is looking at being a pilot site. Strokes and hypertension are a leading risk factor, further drill found that within the workforce there is a growing trend of those who are hypertensive, only 1% were previously identified with high blood pressure. Rules of what is reimbursable is important to them as it could meet Long Term Care needs.

No further testimony IN FAVOR

Opposition to SB 2043

Dr. Patricia Moulton, Executive Director of the North Dakota Center for Nursing, provided testimony OPPOSING SB 2043. (attach #4). (testimony ends 42:30).
Dr. Moulton also provided attachment (Attach #5), ND Center for Nursing, Policy Brief Community Paramedic Pilot Study Recommendations (09/03/2014)

Chairman Judy Lee are you asking that all paramedics need to be supervised by an APRN's?

Dr. Moulton answered no, paramedics can only be supervised by a physician, and so that would leave out APRN's, including other primary care providers. A community paramedic would be very useful in rural areas, but in a lot of cases such as in Watford City, a lot of

providers are APRN's, so they wouldn't even be able to utilize a community paramedic at this time.

Senator Warner discussed a disconnect, where paramedics have relationship with hospital and supervised by doctor employed by the hospital, but we are talking about circumventing hospitals all together and requiring care which would more likely be delivered by clinics or nursing services. Please comment.

Dr. Moulton indicated that is a big part of their recommendations. She indicated it is great to use community paramedics to extend the hospice nurse in some locations, have those people been trained to do that is what the issue is.

Chairman Judy Lee indicated that the expectation that when rules are developed between the two departments that there would be specific training requirements for certain areas of specialty the same as those in various specialty areas of nursing. Further, we are not looking at individual reimbursement but the facility the community paramedic works for the services provided. It would be accurate that they will not get an individual provider number for reimbursement.

Mr. Tom Nehring from the Department of Health indicated regarding reimbursement for community paramedics, the concept of individuals will not be reimbursed. EMS providers are physician extenders, see nurse practitioners are playing that role now. We would see the billing as physician extenders still occurring under the primary team. All paramedics, whether community or not community, is a physician extender.

Chairman Judy Lee disagrees that a nurse practitioner is a physician extender because they are a primary care provider.

Mr. Tom Nehring agrees, but would have no problem seeing community paramedics working with nurse practitioners as well.

Neutral testimony
No neutral testimony was provided.

Closed Hearing.

Note. After the hearing, Chairman Judy Lee received an email from **Dr. Patricia Moulton** that the North Dakota Center for Nursing is changing their position from OPPOSED to NEUTRAL. Reference Attachment #6.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2043
1/13/2015
J# 21912

☐ Subcommittee
☐ Conference Committee

Donald Mueller

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for the services of licensed community paramedics.

Minutes: "Click to enter attachment information."

This set of minutes if from Senate Human Services Committee work.
Job #21912 (7:04)

Chairman Judy Lee indicated that Dr. Patricia Moulton requested that Advanced Practice Nurses be permitted as Primary Care Providers to be supervisors.

Senator Howard Anderson, Jr. indicated that that provision is great with no objection, but indicated this may be in a different section of the law that needs to be addressed in order to add them as supervisors of ambulance personnel and so forth. They need to get themselves added to the statute that says ambulance and EMT's.

Senator Dever indicated they need to define their role in the licensed community paramedics.

Senator Howard Anderson, Jr. indicated yes, back where they are authorized in the first place it says that the physician is the one who supervises them, and the nurse practitioners need to get them added at that level.

Chairman Judy Lee assigned the intern, Femi, for clarification, that in the community paramedic bill, SB 2043, Senator Howard Anderson, Jr. point is that the nurse practitioner as a primary care provider that may be in a different section of statute in order for them to be supervising emergency service personnel. Or is okay for them to be just listed here, which is what they asked, as a supervisor of community paramedics, because right now the community paramedics are supervised by medical directors who are physicians, but NP's are primary care providers also.

Senator Howard Anderson, Jr. suggested contacting Tim Meyer and Tom Nehring in the Department of Health Emergency Services.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2043
1/20/2015
22239

☐ Subcommittee
☐ Conference Committee

Donald Mueller Donald Mueller

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for the services of licensed community paramedics.

Minutes: Attach #1: email from Dr. Moulton

These are notes from committee work on January 20, 2015.

Chairman Judy Lee reviewed the status. The bill is about Licensed Community Paramedics. Several people in spoke in favor, and Chairman Judy Lee noted that Dr. Moulton's position changed from opposed to neutral. (attach #1). The amendment is now written and in front of the committee, prepared by the Intern Femi. The amendment was discussed previously to have provider neutral language. Femi worked with Mr. Tom Nehring from the Health Department in preparing the amendment, being more specific about the responsibility flow. The word "entitling" was also removed and a new sentence structure was added.

Senator Dever asked about the Department of Health's involvement on a Department of Human Services agency bill?

Senator Howard Anderson, Jr. said intention was that Department of Human Services is still in there, but we wanted to be clear that we included advanced practice nurses and changed the word "entitling" to allow payments.

Chairman Judy Lee stated that the Department of Health adopts the rules concerning the scope of practice is for these emergency providers, but the Department of Human Services will be developing the rules on reimbursement.

Senator Howard Anderson, Jr. made a motion to adopt the amendment for SB 2043. The motion was seconded by **Senator Axness**.

Roll Call for Amending SB 2043

6 yes, 0 no, 0 absent

Senator Dever made a motion DO PASS as amended for SB 2043. The motion was seconded by **V. Chairman Oley Larsen.** Discussion indicated it does not need to be re-referred to appropriations since the fiscal note is less than required.

Roll Call for DO PASS as amended for SB 2043

6 yes, 0 no, 0 absent.

Senator Axness will carry the bill.

15.0263.02001
Title.03000

Adopted by the Human Services Committee

January 20, 2015

1/20/15

PROPOSED AMENDMENTS TO SENATE BILL NO. 2043

Page 1, line 3, after "paramedics" insert ", advanced emergency medical technicians, and emergency medical technicians"

Page 1, line 8, replace "entitling" with "governing payments to"

Page 1, line 9, replace "to payment" with ", advanced emergency medical technicians, and emergency medical technicians"

Page 1, line 10, after "to" insert "necessary"

Page 1, line 10, remove "the department determines necessary consistent with"

Page 1, line 11, remove "limitations and exclusions of other medical assistance services"

Page 1, line 11, after the underscored period insert "A physician or an advanced practice registered nurse must supervise any care provided by a licensed community paramedic, an advanced emergency medical technician, or emergency medical technician."

Renumber accordingly

Date: 01/20 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2043

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0263.02001 Title 03000

Recommendation: ☑ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Anderson Seconded By Axness

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Date: 01/20 2015
Roll Call Vote #: 2

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
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Other Actions: ☐ Reconsider ☐ _____

Motion Made By Dever Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larson (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Axness

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

REPORT OF STANDING COMMITTEE

SB 2043: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2043 was placed on the Sixth order on the calendar.

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Renumber accordingly

2015 HOUSE HUMAN SERVICES

SB 2043

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2043
3/11/2015
Job #24655

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for the services of licensed community paramedics, advanced emergency medical techs and emergency medical techs.

Minutes: Testimonies 1-3

Chairman Weisz opened the hearing on SB 2043.

Shelia Sandness: From Legislative Management provided information on the bill. (See Testimony #1)

3:10
Chairman Weisz: The language that says either an advanced practice or physician must supervise the care provided; is that strictly to be able to be reimbursed from the federal standpoint.

Sandness: You can ask the department that.

Cheryl Rising, Legislative liaison for the ND Nurse Practitioner Association testified in support of the bill. (See Testimony #2)

Rep. Fehr: Can you talk about what you see the supervision consists of?

Rising: Nothing has been written on that yet. It is hard to say what the supervising would be.

Rep. Fehr: Would you see the supervisor as being someone who is at a clinic or a hospital?

Rising: It could be. Exactly right.

Chairman Weisz: What type of health related services are you assuming would be provided?

Rising: For the community paramedic?

Chairman Weisz: Yes.

Rising: They are looking at patients that were calling 911 frequently and were the frequent flyers that ended up in the emergency room. The paramedic would go out to that patient and assess them and then call the primary provider and discuss what would be needed for further treatment.

Chairman Weisz: In those cases you will determine what those services are for the paramedic to provide.

Rising: I believe each community that has community paramedics will set up that program so it meets the needs of that community.

Chairman Weisz: What kind of services do you anticipate you are going to utilize the paramedic for that you are going to be billing Medicaid for?

Rising: I can't answer that question.

11:25
Dr. Patricia Moulton: Executive Director of ND Center for Nursing testified in support of the bill. (See Testimony #3)

16:37
Chairman Weisz: When you pointed out the health related services you are really stating (inaudible) what that means?

Mouton: Yes.

Chairman Weisz: And we don't have from your perspective a definition of what you think that should mean?

Mouton: No, we don't at this time.

Rep. Mooney: Did you present this on the Senate side?

Moulton: Yes, and we did testify. Although when the bill was on the Senate side it didn't include the supervision part. We did talk about that there wasn't a licensure and presented a policy recommendation.

Chairman Weisz: It is almost like you are asking that we establish another board.

Moulton: No.

18:25
Kristin North: Representing the Nurse's Association testified in support of the bill. (See Testimony #3)

NO OPPOSITION

21:10
Tom Nehring: Director of Emergency Medical Services and Trauma at the ND Dept. of Health. Rep. Porter you had a question?

Rep. Porter: During the interim there was a study and limited implementation of a pilot project that was performed. In the testimony on the supporting side, both the Nurses Association and the Center for Nursing both came in with opposition to this particular measure in regard to the training, scope of practice and how it is going to work. I want to hear from the department's standpoint on those particular issues.

Nehring: We maintain a neutral position and there may be different degrees of neutral. My neutral position is this; the community paramedic pilot project basically came out of last legislative session. There are two major areas in ND; frequent flyers which are those who use and abuse emergency rooms and ambulance services. This is called the urban model. Fargo-Moorhead ambulance service did a study and found that the top 10 abusers averaged 18 ambulance runs per month. That is 180 ambulance runs per month. They had an equal amount of emergency department visits which were unnecessary. Our focus is on the rural component.

Chairman Weisz: Explain how that community paramedic is addressing that frequent flyer issue.

Nehring: They are assessing the individual at the scene and making a determination whether or not that patient needs to be transported to the hospital. I'll pilot project has focused on the rural areas of ND. The Hospice and home care are not available in all areas of ND. It has focused the rural model on home care. We are no more than an extension of the primary care provider. A primary care provider in this bill is a physician or an advanced practice nurse. We are comfortable with that. When we started the pilot project we also consulted with the Attorney General's Office to determine whether or not this constituted an increased scope of practice. The determination was that it did not. So we moved forward without defining the scope of practice for a paramedic. We use the Hennepin County program out of Minneapolis for education. It is the consensus curricula for the United States for community paramedics. Our next move is to move that educational program within the State of ND. That is occurring now. The bill includes EMT's, advanced EMT's and so forth. We are not ready to move into that pilot project. There is a bill before the Senate that is talking about community health workers. At this point and time they are looking at implementation of the community health representative that service tribal populations and reservations only. However, in the future the combination community health worker and EMT's may provide for us additional coverage in those areas where we have EMT's and advanced EMT's and not paramedics.

Rep. Porter: This bill is specific to one component. This bill says that the services of a licensed community paramedic can be reimbursed by the DHS. If this bill proved to be too complicated and went away; community paramedics are not going to go away in ND they just won't be able to bill for their services to ND Medicaid.

Nehring: You are correct that they won't go away. Minnesota has Medicaid reimbursement for community paramedics. One of the goals we had with community paramedics was sustainability of rural ambulance services and we have a crisis right now with staffing of emergency medical services across the State of ND. Any additional revenue that can come into emergency medical services is important.

Rep. D. Anderson: Is there other sources of funding besides medical reimbursement for the rural communities. How does Minnesota do some of their funding?

Nehring: It varies according to the state. The problem that emergency medical services face is this is a reimbursement model adopted 40 years ago when there were all kinds of Medicaid money and all kinds of payments for ambulances. The survival of ambulance services in ND should be of most importance to all of the citizens. We do offer the rural EMS funding area grants. That is a form of dollars that go to ambulance services. It takes $360,000 a year to maintain one ambulance service at the basic life support level. We have fixed costs of $70,000 and have the volunteer subsidy of about $288,000 per year. As volunteers are dwindling we are trying to get partially paid people or a full time squad leader to take some of the load off from the volunteers. That model would require $31,000 per year to make all ambulance services in ND full time.

Rep. Seibel: How many licensed paramedics do we have in ND? Is their licensure defined somewhere in code or administrative rule?

Nehring: The licensure of community paramedics is going to take place through the Division of Medical Services and Trauma and provided for in rule with specific rules of standards and education they have to undergo.

Rep. Mooney: You talked about the scope of practice and verified with someone that it does not change the scope of practice? Tell me a little more about that.

Nehring: We looked at if we were going to have a scope of practice change. It went through review of the Health Dept. and also consulted with the Attorney General's office, but the current rules apply to the current community paramedics as well. We have to have a new licensure level of community paramedics with specifics. We see the role increasing in responsibility from an environmental perspective. Instead of responding with lights and sirens, the community paramedic will be able to go to the individual's home in concert with the primary provider. The scope of practice won't change it is how and where the practice occurs is going to change.

Rep. Fehr: We don't have a licensure and we need one and because there is no change in the scope of practice, you can do the licensure in rule so this bill will adopt the rule.

Nehring: A agree 100% with you. This bill is about is enabling medical assistance to help reimburse for the care rendered by the community paramedic.

Chairman Weisz: Is there potential here we that we are going to end up with some confusion in billing?

Nehring: I don't believe there is an area of concern here. The billing will occur through the primary care provider.

Rep. Porter: Regarding your statement of gaps in the rural areas. I want to focus back in on the ambulance services in relationship with health care and how it is going to fill those gaps.

Nehring: The problem is in the State of ND typically is services like home care and Hospice are run by the larger organizations. To have an individual going from Bismarck to Washburn does not pay for those organizations so typically those services are not available within those rural communities. There are only two public health departments that really doe home health care visits. That is what this is established for. The community paramedic will follow up chronic disease patients, post-surgical and medication reconciliation. We are looking for filling the gaps out there.

Closed the hearing on SB 2043.

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2043
4/1/2015
25687

☐ Subcommittee
☐ Conference Committee

Amanda Mussha

Relating to medical assistance coverage for the services of licensed community paramedics, advanced emergency medicals techs and emergency medical techs.

Minutes: Handout #1

Chairman Weisz: Let's look at SB 2043. There's an amendment being handed out. (See Handout #1).

Brandon Joyce: From Dept. of Human Services. I am the pharmacy administrator for ND Medicaid. We did let you know about the offers of supplemental rebates that have been made for the department and the fact that we were not able to accept supplement rebates due to legislative intent from 2003. We had a bill in 2003 that asked for us to do supplement rebates along with prior authorization as a preferred drug list and it ended up that there was a competing bill in the house and the legislature went with the house side that didn't have supplemental rebates in it. We are one of three states that do not have supplemental rebates. A supplemental rebate is when you get additional rebates above the federal mandated rebates that manufacturers are required to pay. Hep C is the largest area that had the concern. The medications we don't know how much they are giving in rebates because of federal restrictions on being able to share that data but the department thought it was great enough as to where we should bring this forward. We would end up pooling with other states since we don't have the largest population for Medicaid and then that pool puts out bids for the supplemental amongst the manufacturers within drug classes. They will say to the manufacturers of the hep C medications 'give us your bids, tell us how much money you are willing to pay to gain equal access or preferred access for prior authorization'. Another example is the epi pen. There is one of two products that pay a higher federal rebate so we go with the one single product. In states that have supplemental rebates, they allow both products without prior authorization because the other product is given a supplemental rebate from the company- that same company has offered to do supplemental rebates for ND but we are not able to accept them. If we were we would be able to not have prior authorization in that drug class as a whole. On the hep C side, we would still have prior authorization to ensure that the utilization is appropriate but we would still sell it and not get rid of the prior authorization. We would access rebates that would be significant and the FN would have a start date January 1st, 2016 which we need to do a state plan amendment for. We will be using the template and the supplemental rebates for other states are usually 5-6% of drug save. We are estimating 3% drug save because we are not allowed to do prior authorization in certain drug classes. We

are not asking to change that. The cost for joining the multi-state pool is $19,500 for the first year and 11,200 for the remaining 6 months of the biennium. 3% of the drug save spending for the initial saving would be 1.943 million dollars and then taking away the expenses for that biennium the net rebate savings is 1.901 million in rebates. 50/50 state federal match.

Chairman Weisz: If company A bids a price and so they have preferred access and they are not required or prior authorization can company B come in and say we'll match that so they can also not require prior authorization? Do they have to wait till next year or whenever you bid again?

Joyce: Since this has been in existence for other states since 2002, the process is pretty well bedded out. It is an annual bid process but when new drugs come on the market they will have the opportunity to put in a bid. If they get to a certain point they may get it to where their product won't require prior authorization. On the hep C side of things, it was a mini multi-round bidding process that came out. One company came with a bid and they could ask if they wanted to make a bid. It was a time where it is very significant amount of rebates in the end. When you're talking about medications that cost 100-125,000 a year they went back and forth many times and in some states they ended up choosing to have both products. It is just prior authorization for hep C in general and then there are a few states that went with a final.

Rep. Porter: We pay a membership fee to a multi-state pool but in your explanation using the hep C scenario the state can still have further negotiations with specific companies on drugs or are we in a multi-state pool and we accept their bidding process and that is ours for the one or two year period that the pool has selected?

Joyce: The state wouldn't do any of the initial negotiation. The multi-state pool entity is the one that would do it and it is per one year. Everything is one year.

Rep. Porter: You said that states went even further beyond what the agreement of the multi-state pool was and worked directly with manufacturers and got a better price.

Joyce: That was the pools going back and forth not the individual states.

Chairman Weisz: You said you had a manufacturer that came to you and said if we give you a supplemental rebate will you take us off prior authorization.

Joyce: Right, that's today.

Chairman Weisz: You still have the ability outside of the pool if someone came in on something outside of the pool to negotiate supplemental rebate. You're not stuck within the pool?

Joyce: You would be right, the way that this language is. We would be able to do additional if we wanted. That is not our intent. Our intent is to be able to join a pool since we only have the 70,000 patients. We don't have much clout for negotiation.

Chairman Weisz: Would everything be covered in the pool? If another company comes in and says we will give you supplemental rebate if you take us off prior authorization, you still have the ability to do that correct?

Joyce: Yes

Chairman Weisz: By being a member of the pool doesn't limit you either to do something outside?

Joyce: Correct, with the pool, we would be able to still do negotiations. The other benefit of the pool is that you can choose the different levels. They will have this is their bid if they are one of one drug choice and this is their bid if it's one of two and so on. Each state can choose which level they want, which will determine the rebates they get back. If the DUR board decided in this drug class they wanted both drugs available after prior authorization we wouldn't be restricted based on the pool to only choose the one who gave the best bid. We would be able to do what the DUR board recommended.

Rep. Porter: Then why don't we say the department may join a pool to achieve additional rebates from the drug manufacturers?

Joyce: The issue was simply doing the supplemental rebates. Let's say the pools go away, we didn't want to limit ourselves to only joining the pool, but for negotiations and the feasibility of doing this it is more beneficial for smaller states to do a pool. You have for clout and this language allows us to join a pool and would allow us if a company came in to do rebates with them. I have 13 different drugs where I have had offers in the last four or five years to where they come in asking to do supplemental rebates. I can't predict what they will do.

Rep. Porter: How do we assure that if they are coming to you direct that the process is equal and fair to all manufactures that are making the offers? If the multi-state pool is a bided process and it is bided that way by an independent committee and then adopted by the members then it has the appearance of being a fair process. If company A comes in and says we'll give you more, and then B comes and says we will give you even more, and A comes back and all of a sudden the state is playing the devil's advocate inside of this- I don't like that position. A bid is a bid. I don't mind the ability to having an open bidding process but a winner is a winner. There is a process and the open-endedness concerns me because the process is being tainted because anyone can come in and make another offer. My concerns are having the other system outside of the pool. I don't have an issue joining the pool, I just think there will be a side game going on outside of the pool. How do we assure that we are on the up and up level within doing something like this?

Joyce: Those are valid concerns. The department would not have a problem fixing the amendment. I am open to how to wish to keep it above board and everyone gets that opportunity.

Rep. Fehr: I'm trying to understand the rebate process because it sounds like it is free money. The rebate comes to the state and not to the consumers. If there is this negotiation

why is there a rebate at all and why isn't the price of the drugs being discounted? Is it fixed in federal law somewhere and the only thing adjusted is the rebates? How does that work?

Joyce: I wish we didn't have to deal with rebates but it is a negotiation issue to where the manufacturers give one price to one entity and another price to another. It is the way that market place is. We have some drug classes that are doing 90% rebates on the medications. We are literally paying 1000 each month, and they get 900 dollars back. There are others where we pay 1000 and only get 230 back. It is interesting to note in the supplemental rebate process, there are some of the excluded categories where we can't do prior authorization which we are not asking to change but the anti-psychotics for instance, in the multi-state pools the manufacturer will have you an additional rebate because there is no prior authorization or preference involved. If you are part of a multi-state pool, they toss that in. Right now we can't take that in but with this amendment we could.

Rep. Fehr: In the rebating bidding process how do you know that a supplier who you are contracting with doesn't increase their prices to increase the rebate?

Joyce: There is no assurance from keeping them from doing that.

Rep. Fehr: The prior authorizations, who and what is being authorized?

Joyce: The prior authorization is the process where the department through the DUR board recommendations. They want to prior authorize something based on how much they cost. If drug a is equal to drug b in ethics, but drug b is more than drug a, they want us to prefer drug a. If you want be you have to do a prior authorization that the physician's office will have to explain how they failed it or why they need the other one. If you didn't have the prior authorization the market itself would determine what percentage of each drug would share the market. We prefer a brand name over a generic because we are trying to manage the tax payer dollars.

Rep. D. Anderson: What is the timeframe of getting a rebate back?

Joyce: We have to send out invoices within 60 days of the end of a quarter. We usually get them out about day 50 and that is the end of the quarter. We send out January, February, March invoices in May (20). They have 38 days to pay which is at the end of June.

Rep. Fehr: How do the customers with cost share benefit from rebates?

Joyce: Medicaid law restricts the amount of co pays that are allowed so we charge $3 co-pay at the most. We started the co-pays in 2003 and the day we implemented them we had a 5% shift in brand-generic split. (55% brand 45% generic and then it change to 50/50) When we implemented co-pays we had pharmacies inform us that patients who had picked up their brand name inhalers fore months said ooh I have six of those at home I don't need to pick it up this month because they didn't have any cause to pick it up every month. It wasn't that they weren't going to get it, it's just that they were no longer going to stockpile it. There isn't much way to give back to the patients but the rebates I am not sure on the exact percentages (it may be 40% of our drug budget which goes back to the general fund and that is the benefit for the recipients).

Chairman Weisz: This is only Medicaid population we are talking about here. It doesn't apply to anyone else and same with the rebates. It doesn't apply to the open market. The prior authorization was a big step and I can't remember why we excluded supplemental rebates at the time. It's obvious that we are leaving money on the table and it doesn't change anything with prior authorization pretty much. In reference to Representative Porter's concern- I don't see this as a normal bid process because in reality doing prior authorization is already picking winners and losers because it is based on price if you have a generic that is whatever and the DUR doesn't see a difference it ethics between the products you have to have prior authorization for the higher product. If anything, leaving the language as is, if you do have somebody outside of that pool who is required to have prior authorization and wants to say if we match the generic price in a rebate will you take us off prior authorization- I guess I don't have an issue with that.

Rep. Porter: My issue is with the perception that it could create. If we are allowing in those instances a trade name to come in a match a generic price and then be listed I don't have a problem. I do have the issue is in the standing that if one would come in and then another would and the state would say no we already took one and we aren't going to allow you to do it too. I look at the list from my business stand point and say I want to be on that list because it will benefit my company. If I match this price will you allow me on the list and the state says sure but then your company comes in and says I have the same drug and I want to be on the list to and the state says no you weren't here in time and we are just taking this one.

Chairman Weisz: Your concern is can they be exclusionary instead.

Rep. Porter: Correct, if you're going to let it be an open list, that is why I like the multi-state pool then they are betting that out and choosing. I don't have an issue with the language saying that the department may negotiate, my issue is that it doesn't say the department has to accept everybody that says they will match that price and that is my concern. If you are letting it be that open for the benefit of the state I don't want it to be an exclusive list that once they pick you then I don't get to be on the list.

Rep. Oversen: We are accepting the federally mandated rebates? Are those automatic rebates or is that something that the state has to negotiate?

Chairman Weisz: Those are automatic that are part of the Medicaid system that we don't allow- the department will negotiate or to enter into any outside any rebate agreement beyond that. They can't be part of the pool.

Rep. Oversen: I think where Representative Porter is going but that's not something that could happen currently? As in we can't pick winners or losers the way it is.

Chairman Weisz: In a sense we do pick through the prior authorization process. If they have the same quality, price determines if they are on the list.

Rep. Oversen: Tying to remember what Joyce said that they don't really know what the other company is offering so could they match it?

Chairman Weisz: This would really be language outside of the pool. If drug a did come in and say we can do this for 20 bucks because we know that is where the generics are and they say fine go ahead, and then company c shows up and says we can do it for the 20 bucks they would have to allow it. This would be outside of the pool. This doesn't affect the pool.

Rep. Porter: That would take care of my concerns. I don't want there to be any exclusion. I move the amendment with the additional language of

Rep. Oversen: Second. I wonder if the portion that says on their own shouldn't be more specific either outside of the pool or outside of existing rebates.

Representative Fehr: I think because of the pool system and then anybody else that wanted to come in and match inside of that, I think the DUR board has the ability to look at those things and accept them or not as they come back and forth. The pool is one thing but it is the outside of the pool potentials.

Representative Oversen: I am just asking if that language of negotiate on their own if the words on their own make sense in code.

Chairman Weisz: You leave that language out, they would negotiate. In other words they department has the ability outside of the pool to negotiate but if you just say if the department negotiates additional rebates outside the pool any other manufacture must be allowed to match those rebates. That would be the better.

Representative Fehr: I am wondering if we got an indication from the department if the additional language would create any problems.

A Voice Vote Was Taken: Motion Carries

Representative Porter: I move a do pass as amended

Representative Fehr: Second

A Roll Call Vote Was Taken: Yes 13, No 0, Absent 0

Motion carries

Representative Porter will carry the bill

A new subsection to section 50-24.6-04 of the North Dakota Century Code is created and enacted as follows:

The department may negotiate additional rebates from drug manufacturers to supplement the rebates required by federal law governing the medical assistance program."

15.0263.03001
Title.04000

Adopted by the Human Services Committee 4/1/15

April 1, 2015

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2043

Page 1, line 1, after "50-24.1" insert "and a new subsection to section 50-24.6-04"

Page 1, line 3, remove "and"

Page 1, line 3, after "technicians" insert ",drug manufacturer rebates"

Page 1, after line 13, insert:

"**SECTION 2.** A new subsection to section 50-24.6-04 of the North Dakota Century Code is created and enacted as follows:

The department may negotiate additional rebates from drug manufacturers to supplement the rebates required by federal law governing the medical assistance program. Additionally, the department may join a multistate supplemental drug rebate pool, and if the department negotiates additional rebates outside this pool, any other manufacturer must be allowed to match those rebates."

Renumber accordingly

Date: 4-1-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2043

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: See Attachment 1

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Oversen

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker	Voice Vote				
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

additional language of the department

Date: 4-1-15
Roll Call Vote #: 2

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2043

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0263.03061

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Fehr

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen	✓	
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment Rep. Porter

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

REPORT OF STANDING COMMITTEE

SB 2043, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2043 was placed on the Sixth order on the calendar.

Page 1, line 1, after "50-24.1" insert "and a new subsection to section 50-24.6-04"

Page 1, line 3, remove "and"

Page 1, line 3, after "technicians" insert ",drug manufacturer rebates"

Page 1, after line 13, insert:

"**SECTION 2.** A new subsection to section 50-24.6-04 of the North Dakota Century Code is created and enacted as follows:

The department may negotiate additional rebates from drug manufacturers to supplement the rebates required by federal law governing the medical assistance program. Additionally, the department may join a multistate supplemental drug rebate pool, and if the department negotiates additional rebates outside this pool, any other manufacturer must be allowed to match those rebates."

Renumber accordingly

2015 TESTIMONY

SB 2043

#1 SB2043 pg 1 Attach #1 J#21868 01/13/15

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 Bill No. 2043 relating to medical assistance coverage for the services of licensed community paramedics. I appear neither for nor against the bill, but just to provide information and answer any questions you may have.

Senate Concurrent Resolution No. 4002, approved by the Legislative Assembly in 2013, directed 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. This study was assigned to the interim Health Services Committee. In addition, the Legislative Assembly approved, in 2013 Senate Bill No. 2004, $276,600 from the general fund for 1 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 interim Health Services Committee received information regarding the pilot project, including training, licensing, and supervision of community paramedics. The committee also received information regarding services and potential for reimbursement.

The interim Health Services Committee recommends Senate Bill No. 2043 to require the Department of Human Services adopt rules entitling licensed community paramedics to payment for health-related services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary consistent with how limitations are set for other medical assistance services. A fiscal note, prepared by the Department of Human Services, assumes a

July 1, 2016, implementation to allow adequate time for the department to adopt rules. The department estimates 2015-17 biennium expenditures will increase by $36,000, of which $18,000 is from the general fund and $18,000 is from federal funds. In addition, the department estimates 2017-19 biennium expenditures will increase by $76,380, of which $38,190 is from the general fund and $38,190 is from federal funds.

The Health Services Committee's findings and recommendation regarding the community paramedic study can be found in the "Report of the North Dakota Legislative Management".

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

Attach #2 SB2043
J#21868 01/13/15

Senate Bill 2043
Sixty-fourth Legislative Assembly
Testimony of Mike Reitan, Chief of Police, West Fargo Police Department

Good morning Chairman Lee, Vice Chair Larsen and members of the Human Services Committee. My name is Mike Reitan and I am the Chief of Police of the West Fargo Police Department. I ask your support of Senate Bill 2043.

There exists in my community and in many other communities across the state of North Dakota a population of citizens who are unable to completely function on their own but who are not compromised to the point they need intensive care. They are the ones who have been recently discharged from the hospital without a care provider in the home. They may be the person in the early stages of Alzheimer's, dementia or a debilitating illness. They live in their homes without adequate monitoring and are just one slip or missed medication away from becoming a medical emergency.

At times, some of these clients will receive the moniker of frequent flier from emergency response personnel due to the number of calls made to their home. The calls are made because the person is truly in need of assistance but the assistance often times does not rise to the level of emergency care. To have repeated emergency responses to the home is terribly inefficient and a drain on resources.

In my community there is a pilot community paramedic program that has proven highly effective in addressing the issue of providing the necessary level of care and allows resources to remain available to other parts of the community. To provide funding for the implementation and expansion of a licensed community paramedic program would greatly improve the quality of service to the individual and create a greater effectiveness and efficiency in health care services across North Dakota.

I thank you for your time and stand for any questions you may have.

Michael D Reitan
Chief of Police, West Fargo
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701-367-1708 Mobile
Mike.reitan@westfargond.gov

American Heart Association | American Stroke Association
life is why

#1 SB2043
J# 21868
01/13/15

Senate Bill 2043
Senate Human Services Committee
Testimony

June Herman
American Heart Association

Good morning Chairman Lee and members of the Senate Human Services Committee. For the record, I am June Herman, Regional VP of Advocacy for the American Heart Association. I ask for your Do Pass recommendation on SB 2043.

I serve on one of the stakeholder groups engaged on looking at application elements of Community Paramedics in North Dakota. Community paramedicine provides a valued service for unmet needs in our state. The reimbursement for health services provided within their scope of practice is a reasonable step while also enabling a stable level of paramedic service for the region.

#4 SB2043
01/13/15
J# 21868

NORTH DAKOTA
CENTER FOR NURSING
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ND Senate Human Services Committee

SB 2043: Relating to Medical Assistance Coverage for the Services of Licensed Community Paramedics.

January 13, 2015 Testimony

Chairman Lee and members of the Senate Human Services Committee, I am Dr. Patricia Moulton, Executive Director of the North Dakota Center for Nursing. Today, I am providing testimony in opposition to SB 2043 relating to medical assistance coverage for the services of licensed community paramedics. I have attached a policy brief to my testimony today which was created by the North Dakota Center for Nursing and was developed to represent over 17,000 nurses and more than forty nursing organizations across North Dakota.

There are gaps in North Dakota's health care delivery system, especially in rural areas that new roles such as community paramedics could help fill. However, careful consideration needs to be made to ensure quality and safe patient care within an interprofessional team of health care providers. Our policy brief outlines twelve policy recommendations related to the development of the community paramedic program in North Dakota.

Related specifically to SB 2043 is recommendation one, which indicates that through legislation during the 2015 session, a scope of practice to better define the community paramedic role and skill set and to include a provision for Advanced Practice Registered Nurses to also supervise community paramedics. SB 2043 directs the ND Department of Human Services to adopt rules to entitle licensed community paramedics to payment for health-related services. Currently, there is not a licensure for community paramedics. There is for paramedics but not as community paramedics. The current scope of practice for paramedics is focused on the provision of acute care and an interface with the hospital rather than a community setting. A defined scope of practice for community paramedics would provide a set of guidelines for the role and required training for community paramedics.

SB 2043 directs the ND Department of Human Services to adopt rules entitling licensed community paramedics to payment for health-related services provide to recipients of medical assistance. These services are currently not defined. Our policy brief recommendation eight indicates that limited and short-term /emergent interventions paired with appropriate community paramedic training should be established. As is the case with model community paramedic programs located in other states, such as Colorado, a different type of training is needed depending on whether community paramedics will provide in-home patient visits or community services and that training and specific interventions should be paired with appropriate training and established scope of practice. We include a list of examples of the types of services that have been suggested by a national study on Community Paramedicine.

Thank you for the opportunity to speak on behalf of the many nursing organizations that are a part of the ND Center for Nursing.

SB2043
Attach #5 01/13/15
J#21868

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University Partnership Research Grant for Health Professional Opportunities
Williston State College Nursing Program
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NORTH DAKOTA CENTER FOR NURSING

A unified voice in nursing excellence.

Policy Brief

Community Paramedic Pilot Study Recommendations

September 3, 2014

Executive Summary

The North Dakota Center for Nursing is a non-profit, 501c3 organization that was developed to represent over 17,000 nurses and 40+ nursing organizations across North Dakota. The mission of the North Dakota Center for Nursing is to guide the ongoing development of a well-prepared and diverse nursing workforce to meet the needs of the citizens of North Dakota through research, education, recruitment and retention, advocacy and public policy. This policy brief has been approved by our Board of Directors and is an official policy of the ND Center for Nursing.

There are gaps in North Dakota's health care delivery system, especially in rural areas that new roles such as community paramedics could help fill.[5] However, careful consideration needs to be made in order to ensure quality and safe patient care within an interprofessional team of health care providers is provided. The North Dakota Center for Nursing embraces innovative patient/family/community/population care models that ensure safe and quality care. These policy recommendations are designed to ensure that implementation of the Community Paramedicine Program will result in every patient receiving safe, quality care through the coordinated effort of all health care providers.

Policy Recommendations

1. Through legislation during the 2015 session, develop a scope of practice to better define the community paramedic role and skill set and to include a provision for Advanced Practice Registered Nurses to also supervise community paramedics.
2. Require uniform education and training program including core components.
3. Define the referral process for each community paramedic program.
4. Require community paramedics to utilize a community needs assessment to identify key focus areas for their work.
5. Establish greater statewide linkages and referrals for mental health and substance abuse services.
6. Develop a realistic, sustainable funding model.
7. Provide limited short term services **only** if those services are not available in their geographic location or a patient doesn't qualify for home health, public health, hospice, school health or other resources.

8. Establish **limited and short term/ emergent** interventions paired with appropriate community paramedic training.
9. Through legislation during the 2015 session, include provider-neutral language in order to ensure that Advanced Practice Registered Nurses are able to supervise/delegate to community paramedics.
10. Through legislation during the 2015 session, provide clear definition and reporting lines for accountability and mechanism for documentation of care including provider orders.
11. Establish a standardized approach across jurisdictions that facilitates statewide program evaluation using national guidelines for evaluation.
12. Require additional ongoing training reflecting the changing needs of the community or evolving health issues.

Introduction

The North Dakota Center for Nursing is a non-profit, 501c3 organization that was developed to represent over 17,000 nurses and 40+ nursing organizations across North Dakota. The mission of the North Dakota Center for Nursing is to guide the ongoing development of a well-prepared and diverse nursing workforce to meet the needs of the citizens of North Dakota through research, education, recruitment and retention, advocacy and public policy. This policy brief has been approved by our Board of Directors and is an official policy of the ND Center for Nursing.

The North Dakota Center for Nursing embraces innovative models to ensure safe and quality care. Every patient deserves access to safe, quality care from all healthcare providers. Health care delivery is ever-changing and is currently undergoing a significant transformation due to changes in the population and implementation of the Affordable Care Act. The North Dakota Center for Nursing supports initiatives which allow all members of the healthcare team to fully function consistent with their education and scope of practice as interprofessional partners.

Patient centered care coordination is a foundational element of nursing practice and is at the heart of nursing practice which makes nursing an integral partner of the health care team. The Institute of Medicine in 2003[1] emphasized the impact of coordination of care on improving the quality of care. In the Institute of Medicine 2011 report, this care coordination was cited as one of the traditional strengths of the nursing profession whether in the community or in the acute care setting[2].

The Community Paramedicine Program has the potential to operationalize the Institute for Healthcare Improvement Triple Aim[3] of decreasing healthcare costs, improving health outcomes and improving patient experiences. These outcomes should serve as the basis for program evaluation and provide the definition of success.

Certainly there are gaps in North Dakota's health care delivery system, especially in rural areas that new roles such as community paramedics could help fill.[3] However, careful consideration needs to be made in order to ensure quality and safe patient care within an interprofessional team of health care providers is provided. The National Consensus Conference on Community Paramedicine funded by the Agency for Healthcare Research and Quality (2012) explored the incorporation of community paramedics within the interdisciplinary health workforce environment. The study indicated that as standards of care and protocols evolve with increasingly interdependent roles between community paramedic providers and others in the healthcare system, it is necessary to determine the specific aspects of care for which community paramedic providers will be held accountable. The study recommended that successful integration of community paramedics will involve fulfilling six Cs[4]:

- *Community: addressing a current unfulfilled need;*
- *Complementary: enhancement without duplication;*
- *Collaborative: interdisciplinary practice;*
- *Competence: qualified practitioners ;*
- *Compassion: respect for individuals;*
- *Credentialed: legal authorization to function.*

Our policy recommendations are designed to help fulfill these and to help ensure that quality care is provided with no duplication of services to the citizens of North Dakota.

Policy Recommendations

1. **Through legislation during the 2015 session, develop a scope of practice to better define the community paramedic role and skill set and to include a provision for Advanced Practice Registered Nurses to also supervise community paramedics.** The current scope of practice (Century Code 33-36-04-02)[6] for a paramedic is focused on the provision of acute care and an interface with the hospital rather than the community setting. The Western Eagle County Health Services District in Colorado[7] indicated that it will be important to develop policies and procedures that provide explicit boundaries around the program.

2. **Require uniform education and training program including core components**. Uniform education and clinical training from an accredited program in the higher education setting consistent with the functions of the community paramedic role, should be required by state statue.[8] The American Nurses Association recommends that accredited educational programs should include core components from social and behavioral sciences and social determinants such as:

    1. *Cultural competency;*
    2. *Community roles and resources;*
    3. *Health Assessment;*
    4. *Personal Safety;*
    5. *Professional Boundaries*
    6. *Clinical components that include sub-acute and semi-chronic patient needs*

    The educational program should also include components on interprofessional role development such as role clarification, patient/client/family/ community centered care, team functioning, collaborative leadership, interprofessional communication and dealing with interprofessional conflict.[9] Currently, the pilot program has been utilizing the Hennepin Technical College Community Paramedic Program. It is not known whether this program includes all of the core components listed above.

3. **Define the referral process for each community paramedic program.** This includes how orders are transmitted between providers, the procedure for connecting patients with community paramedics, referring patients to other services and refusing care. Effective referral is important in maintaining continuity of care and are especially important for coordinating care between settings such as a hospital and a community.[8,10]

4. **Require community paramedics to utilize a community needs assessment to identify key focus areas for their work.** Community paramedics should utilize existing resources. The Western Eagle County Health Services District in Colorado[7] indicated that the community needs assessment can determine:

    - *The leading causes of preventable morbidity and mortality;*
    - *Gaps in health care services;*
    - *Demographics of the populations most impacted by the gaps;*
    - *Characteristics of those who most frequently use the ambulance service;*
    - *Most frequent conditions requiring hospital admission;*
    - *The greatest health care needs as seen by local medical providers;*

    Local public health units are experienced in conducting these assessments. All hospitals including Critical Access Hospitals have also conducted community needs assessments. The assessment would be used to customize the scope of the program to the needs of that community. Prior to implementation community paramedics should meet with key community partners including health care agencies, home health, public health, hospice and school health in each community in order to ensure coordination and no duplication of services. A written resource guide which includes available resources should be available for the community paramedic.

5. **Establish greater linkage and referral statewide for mental health and substance abuse services.** According to testimony by F-M Ambulance Service,[15] the primary reasons an ambulance is called for the top ten frequent users in the Fargo/Moorhead area are mental health issues (50%), diabetes complications (20%), seizures (20%) and substance abuse (10%). Greater linkage and referral is needed statewide for mental health and substance abuse services. An electronic, online, statewide directory of referrals for all health care providers to use within a team including but not limited to home health, faith/community nurses, public health, mental health, dentists, AA, substance abuse and recovery services should be developed to facilitate greater integration of services. The ND Behavioral Health Planning Final Report[16] also indicated the need to develop a one-stop-shop for behavioral health services in order to better track and improve access to services.

6. **Develop a realistic, sustainable funding model.** According to the Community Paramedic Study Background Memorandum prepared by Legislative Council[11], 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;*
    6. *School wellness and mid-level clinical services.*

    These potential services are very broad and in some cases require training beyond paramedic and community paramedic training and scope of practice (such as chronic disease management). The use of the term mid-level is inappropriate and outdated. The "call-a-nurse" service references a particular professional group and the title "nurse" is a protected title with a defined scope of practice and educational requirements. It is also unclear as to how these potential services, if linked with appropriate training and scope of practice changes, would become billable services and provide reimbursement for this program. Implementing this program is costly and is not fundable through a one-time payment.

7. **Provide limited short term services only if those services are not available in their geographic location or a patient doesn't qualify for home health, public health, hospice, school health or other resources.** Community paramedic services should not replace a patient's qualification for an existing services such as home health, public health, hospice and school health. Services by a community paramedic such as patient health assessments should only be offered if services are not available because the patient doesn't qualify for home health or the resources are not available in their geographical location. Services should be provided on a limited, short-term basis. Long term chronic disease management should be referred to other services. The Western Eagle County Health Services District in Colorado[7] indicated that in-home care that is delivered by a Community Paramedic is not of an ongoing nature (such as that provide by a home care agency), but rather each visit requires a discreet order from the patient's referring and/or primary care provider.

8. **Establish limited and short term/ emergent interventions paired with appropriate community paramedic training.** Community Paramedics can be relevant to both rural and urban areas, but these communities have different capabilities and different needs.[4] For example, the goal of the urban program is to reduce repeat ambulance/911 calls. The rural program revolves around filling gaps in health care delivery. The Western Eagle County Health Services District in Colorado[7] indicated that a different type of clinical training is needed depending on whether the Community Paramedics will provide in-home patient visits or community based services and that the services are within the legal scope of practice for paramedics. Possible community paramedic interventions include: [4]

    - *Home assessments (e.g. safety) ;*
    - *Patient resource needs assessments (e.g. food);*
    - *Assisting patients to manage their own healthcare (diabetes, CHF);*

- *Acute care response to reduce hospitalization;*
- *Supportive care for assisted living populations;*
- *Support for family caregivers;*
- *Post-discharge follow-up to prevent readmissions;*
- *Medication reconciliation and compliance;*
- *Behavioral health follow-up to increase attendance at appointments;*
- *Assessment with triage and referral.*

Specific protocols for Community Paramedics for each possible type of intervention should be developed using evidence based practice methods. Eagle County Paramedic Services has developed specific protocols for their Community Paramedics for each possible type of intervention within their system.[12]

9. **Through legislation during the 2015 session, include provider-neutral language in order to ensure that Advanced Practice Registered Nurses are able to supervise/delegate to community paramedics.** The American Association of Nurse Practitioners and the North Dakota Nurse Practitioner Association support the use of provider neutral langauge.[13] The Western Eagle County Health Services District in Colorado[7] also indicated the supervision and delegation to Community Paramedics may occur via physicians or advanced practice nurses.

10. **Through legislation during the 2015 session, provide clear definition and reporting lines for accountability and mechanism for documentation of care including provider orders.** Identify appropriate models for providing medical direction within varied Community Paramedic settings and services.[4] The Eagle County Community Program protocols manual included a medical direction and chain of command policy.[12] The chain of command should reflect provider-neutral language.

11. **Establish a standardized approach across jurisdictions to provide statewide program evaluation.** This approach should be developed by consensus of key stakeholders. This would allow for comparisons across the state. In addition to tracking decreased ER visits and hospital readmissions, evaluation should extend to include monitoring for outcomes, patient satisfaction and a decrease in adverse outcomes,[8] cost savings, compliance with medication regimens, attendance at appointments and information on patients that fall through gaps. The Western Eagle County Health Services District in Colorado[7] also indicated that the evaluation should include a method for tracking patients including the response times, percentage of uninsured, Medicaid and Medicare patients, age range, number of visits, leading types of chief complaints and leading outcomes of visits. The U.S. Department of Health and Human Services, Health Resources and Services Administration has developed an evaluation tool for Community Paramedicine programs.[14] The evaluation tool is designed to provide a common framework by which data can be collected from multiple Community Paramedicine programs and aggregated to provide a snapshot of common successes and challenges. The Agency for Healthcare Research and Quality National Consensus Conference on Community Paramedicine,[4] also indicated the need to for careful strategic evaluation. The North Dakota program should include these recommendations in designing its statewide program evaluation.

12. **Require additional ongoing training reflecting the changing needs of the community or evolving health issues.** With the prevalence of mental health and substance abuse calls cited in #5, community paramedics should also receive additional training such as Mental Health First Aid. This was also cited in the ND Behavioral Health Planning Final Report.[16] As additional issues are identified appropriate training should be developed.

In summary, the North Dakota Center for Nursing supports innovative models to ensure safe and quality care. Our policy recommendations are designed to ensure that successful implementation of the Community Paramedic program will result in every patient receiving safe, quality care through the coordinated effort of all health care providers.

References

1. Institute of Medicine (2003). Priority Areas for National Action: Transforming Health Care Quality. Website accessed 07/24/2013 http://iom.edu/Reports/2003/Priority-Areas-for-National-Action-Transforming-Health-Care-Quality.aspx

2. Institute of Medicine (2011) Future of Nursing: Leading Change, Advancing Health. Website accessed 07/24/2013 http://www.iom.edu/Reports/2010/the-future-of-nursing-leading-change-advancing-health.aspx

3. Institute for Healthcare Improvement Triple Aim Website accessed 07/24/2013 http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

4. Patterson, DG, Skillman, SM. (2013). National Consensus Conference on Community Paramedicine: Summary of an Expert Meeting. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; pages 6, 9, 23 quoted in brief. Website accessed 07/24/2014 http://depts.washington.edu/uwrhrc/uploads/CP_Report.pdf

5. Pearson, K., Gale, J., Shaler, G. (2014). Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program. Flex Monitoring Team Policy Brief #35. Website accessed 07/24/2014 http://www.flexmonitoring.org/publications/pb35/

6. ND Century Code Scope of Practice for Emergency Medical Services Professionals Website accessed 07/24/2014 http://www.legis.nd.gov/information/acdata/pdf/33-36-04.pdf?20140724160715

7. North Central EMS Institute. (2011). Western Eagle County Health Services District Community Paramedic Program Handbook. Website accessed 07/24/2014 http://communityparamedic.org/Program-Handbook

8. American Nurses Association (2014). ANA's Essential Principles for Utilization of Community Paramedics. Website accessed 07/24/2014 http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/ANAPrinciples/EssentialPrinciplies-UtilizationCommunityParamedics.pdf

9. Eisler, R. & Potter, T.M. (2014). Transforming Interprofessional Partnerships. Indianapolis, IN: Sigma Theta Tau International Honor Society of Nursing.

10. Edwards, N., Davies, B., Ploeg, J., Virani, T. & Skelly, J. (2007). Implementing Nursing Best Practice Guidelines: Impact on Patient Referrals. BMC Nursing, 6:4, p. 1-9. Website accessed 07/24/2014 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1947981/

11. North Dakota Legislative Council (2013). Community Paramedic Study: Background Memorandum. Website accessed 07/24/2014 http://www.legis.nd.gov/files/events/memorandum/15.9013.01000.pdf?20140724161809

12. Eagle County Paramedic Services (2013). Community Paramedic Protocols Manual.

    Website accessed 07/24/2014 http://ircp.info/Portals/11/Downloads/Tools/Eagle%20County%20Paramedics%20Community%20Paramedic%20Protocols.pdf

13. North Dakota Nurse Practitioners Association (2014). Report to Community Paramedic Stakeholders Meeting. Website accessed 07/24/2014 http://www.ndcenterfornursing.org/wp-content/uploads/2014/07/REPORT-TO-COMMUNITY-PARAMEDIC-STAKE-HOLDERS-MEETING-march-2014-final-draft.docx

14. U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy (2012). Community Paramedicine Evaluation Tool. Website accessed 07/24/2014 http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf

15. F-M Ambulance Service (2013). Testimony: Community Paramedic Study Senate Concurrent Resolution, No. 4002 Health Services Committee Website accessed 07/24/2014 http://www.legis.nd.gov/files/committees/63-2013nma/appendices/15_5038_03000appendixq.pdf?20140724162613

16. Schulte Consulting, LLC (2014). North Dakota Behavioral Health Planning Draft Final Report. Website accessed 07/24/2014 http://www.legis.nd.gov/files/committees/63-2013nma/appendices/15_5107_03000appendixb.pdf?20140724162912

Attach #6
SB 2043
01/13/15
J#21868

From: Patricia Moulton <patricia.moulton@ndcenterfornursing.org>
Date: January 14, 2015 at 5:35:20 PM CST
To: <jlee@nd.gov>
Subject: SB 2043

Senator Lee,

Following the hearing on the community paramedic reimbursement bill, the ND Center for Nursing would like to change our position to neutral. I have attached revised testimony. We would be happy to provide any assistance needed during the administrative rules process in the event this bill passes, especially in relation to the recommendations in our policy brief.

Thank you,

Patricia Moulton, PhD
Executive Director
ND Center for Nursing
patricia.moulton@ndcenterfornursing.org
701-365-0408
417 Main Avenue Suite #402
Fargo, ND 58103
www.ndcenterfornursing.org

SB 2043 Attach #1 01/20/15
J# 22239

NDLA, S HMS - Mueller, Don

From: Lee, Judy E.
Sent: Wednesday, January 14, 2015 9:13 PM
To: NDLA, S HMS - Mueller, Don
Cc: Larsen, Oley L.; Anderson, Jr., Howard C.; Dever, Dick D.; Axness, Tyler; Warner, John M.
Subject: Fwd: SB 2043
Attachments: ATT00001.htm; Revised SB 2043 Testimony January 14 2015.docx; ATT00002.htm; PolicyBrief-CommunityParamedic.pdf; ATT00003.htm

Please note that Dr. Moulton's position on 2043 has changed.
Don, please remind us to make a note of this on her testimony in our books.

Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
Phone: 701-282-6512
e-mail: jlee@nd.gov

Begin forwarded message:

> **From:** Patricia Moulton <patricia.moulton@ndcenterfornursing.org>
> **Date:** January 14, 2015 at 5:35:20 PM CST
> **To:** <jlee@nd.gov>
> **Subject: SB 2043**
>
> Senator Lee,
>
> Following the hearing on the community paramedic reimbursement bill, the ND Center for Nursing would like to change our position to neutral. I have attached revised testimony. We would be happy to provide any assistance needed during the administrative rules process in the event this bill passes, especially in relation to the recommendations in our policy brief.
>
> Thank you,
>
> Patricia Moulton, PhD
> Executive Director
> ND Center for Nursing
> patricia.moulton@ndcenterfornursing.org
> 701-365-0408
> 417 Main Avenue Suite #402
> Fargo, ND 58103
> www.ndcenterfornursing.org
>
> *This email is for informational purposes only. Please do not respond by replying all to comply with open meeting laws and mandates.*

SB 2043
3-11-15
#1

Mister Chairman, 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 Bill No. 2043 relating to medical assistance coverage for the services of licensed community paramedics. I appear neither for nor against the bill, but just to provide information and answer any questions you may have.

Senate Concurrent Resolution No. 4002, approved by the Legislative Assembly in 2013, directed 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. This study was assigned to the interim Health Services Committee. In addition, the Legislative Assembly approved, in 2013 Senate Bill No. 2004, $276,600 from the general fund for 1 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 interim Health Services Committee received information regarding the pilot project, including training, licensing, and supervision of community paramedics. The committee also received information regarding services and potential for reimbursement.

The interim Health Services Committee recommends Senate Bill No. 2043 to require the Department of Human Services adopt rules entitling licensed community paramedics to payment for health-related services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary consistent with how limitations are set for other medical assistance services.

The Health Services Committee's findings and recommendation regarding the community paramedic study can be found in the "Report of the North Dakota Legislative Management".

Senate Bill No. 2043, as amended by the Senate Human Services Committee, directs the Department of Human Services to adopt rules governing payments to licensed community paramedics and emergency medical technicians for health-related services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary. A fiscal note, prepared by the Department of Human Services, assumes a July 1, 2016, implementation to allow adequate time for the department to adopt rules. The department estimates 2015-17 biennium expenditures will increase by $36,000, of which $18,000 is from the general fund and $18,000 is from federal funds. In addition, the department estimates 2017-19 biennium expenditures will increase by $76,380, of which $38,190 is from the general fund and $38,190 is from federal funds.

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

#2

NDNPA
North Dakota Nurse Practitioner Association

3-11-15

Testimony on Senate Bill 2043

Chairman Weisz and Committee Members

I am Cheryl Rising, FNP and legislative liaison for the North Dakota Nurse Practitioner Association (NDNPA). We support Bill 2043 in relation to community paramedics.

Advance practice registered nurses (APRNs) are included on line 13 which allows us to supervise and give orders on patients that we are primary providers of.

Most communities have APRNs as providers in the community. Some communities the APRN is the sole provider. It is imperative that the APRN be included in this bill to prevent barriers to health care in our state.

Cheryl Rising, FNP

701-527-2583

#3

NORTH DAKOTA CENTER FOR NURSING
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ND House Human Services Committee

SB 2043: Relating to Medical Assistance Coverage for the Services of Licensed Community Paramedics

March 11, 2015 Testimony

Chairman Weisz and members of the House Human Services Committee, I am Dr. Patricia Moulton, Executive Director of the North Dakota Center for Nursing. I have attached a policy brief to my testimony today which was created by the North Dakota Center for Nursing and was developed to represent over 17,000 nurses and more than forty nursing organizations across North Dakota.

There are gaps in North Dakota's health care delivery system that new roles such as community paramedics could help fill. However, careful consideration needs to be made to ensure quality and safe patient care within an interprofessional team of health care providers. Our policy brief outlines twelve policy recommendations related to the development of the community paramedic program in North Dakota. We certainly support innovative models for health care delivery so are neutral on this bill, but have several suggested amendments to help clarify pieces of the bill.

SB 2043 directs the ND Department of Human Services to adopt rules to entitle licensed community paramedics, advanced emergency medical technicians and emergency medical technicians to payment for health-related services. Currently, there is not a licensure for community paramedics. Century Code 23-27-02 defines Emergency Medical Services as "the prehospital medical stabilization or transportation of an individual who is sick, injured, wounded, or otherwise incapacitated or helpless, or in a real or perceived acute medical condition..."

SB 2043 also directs the ND Department of Human Services to adopt rules entitling licensed community paramedics to payment for health-related services provided to recipients of medical assistance. Many possible services have been suggested for Community Paramedic during the ND Community Paramedic Pilot Study, other states and a national study. Our policy brief provides more detail about these possible services, but they include home assessments, patient resource needs assessments, assisting patients to manage their own healthcare, supportive care for assisted living population, post-discharge follow-up to reduce readmissions, behavioral health follow-up, hospice and support for family caregivers. These services do not fall within the current definition of Emergency Medical Services which emphasizes acute care.

We would like to suggest an amendment to provide for a definition of a community paramedic in Century Code 23-27-02 and the addition that the state health council adopt rules prescribing minimum training, testing, certification, licensure and quality review standards for community paramedics in Century Code 23-27-04.3. We recommend that community paramedics provide limited short term services only if those services are not available in their geographic location or a patient doesn't qualify for home health, public health, hospice, school health or other resources

(policy recommendation 7). A defined list of interventions that are limited and short term/emergent should also be developed and paired with appropriate training.

A defined scope of practice that is linked with training to would also be needed for advanced emergency medical technicians (AEMTs) and emergency medical technicians (EMTs) that provide community paramedic services. AEMTs and EMTs have substantially less training than paramedics. The ND Community Paramedic Pilot Program currently utilizes the Hennepin Technical College training program for community paramedics. This program is designed for those that are licensed paramedics and not AEMTs and EMTs. A training program would need to be developed

SB 2043, which creates a new section in chapter 50-24.1 states, "A physician or an advanced practice registered nurse must supervise any care provided by a licensed community paramedic, an advanced emergency medical technician, or emergency medical technician". We are supportive of the inclusion of the advanced practice registered nurse as the current law only allows physicians to provide medical direction to paramedics and emergency medical personnel (Century Code 23-27-04.1). This is included as policy recommendation nine on our policy brief. Exclusion of advanced practice registered nurses would be a barrier in rural areas of the state.

As Century Code 50-24.1 details medical assistance for needy persons, we would like suggest an amendment that this language is moved to ND Century Code 23-28-04.1

In summary, although we support innovate models to deliver health care in North Dakota, at this time there are many unanswered questions regarding how community paramedics can be implemented. Especially while ensuring safe patient care, and with the addition of EMTs to the program. Thank you for the opportunity to represent the many nursing organizations that are a part of the ND Center for Nursing.

SB 2043
3-11-15
3b

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Policy Brief

Community Paramedic Pilot Study Recommendations

September 3, 2014

Executive Summary

The North Dakota Center for Nursing is a non-profit, 501c3 organization that was developed to represent over 17,000 nurses and 40+ nursing organizations across North Dakota. The mission of the North Dakota Center for Nursing is to guide the ongoing development of a well-prepared and diverse nursing workforce to meet the needs of the citizens of North Dakota through research, education, recruitment and retention, advocacy and public policy. This policy brief has been approved by our Board of Directors and is an official policy of the ND Center for Nursing.

There are gaps in North Dakota's health care delivery system, especially in rural areas that new roles such as community paramedics could help fill.[5] However, careful consideration needs to be made in order to ensure quality and safe patient care within an interprofessional team of health care providers is provided. The North Dakota Center for Nursing embraces innovative patient/family/community/population care models that ensure safe and quality care. These policy recommendations are designed to ensure that implementation of the Community Paramedicine Program will result in every patient receiving safe, quality care through the coordinated effort of all health care providers.

Policy Recommendations

1. Through legislation during the 2015 session, develop a scope of practice to better define the community paramedic role and skill set and to include a provision for Advanced Practice Registered Nurses to also supervise community paramedics.
2. Require uniform education and training program including core components.
3. Define the referral process for each community paramedic program.
4. Require community paramedics to utilize a community needs assessment to identify key focus areas for their work.
5. Establish greater statewide linkages and referrals for mental health and substance abuse services.
6. Develop a realistic, sustainable funding model.
7. Provide limited short term services **only** if those services are not available in their geographic location or a patient doesn't qualify for home health, public health, hospice, school health or other resources.

8. Establish **limited and short term/ emergent** interventions paired with appropriate community paramedic training.
9. Through legislation during the 2015 session, include provider-neutral language in order to ensure that Advanced Practice Registered Nurses are able to supervise/delegate to community paramedics.
10. Through legislation during the 2015 session, provide clear definition and reporting lines for accountability and mechanism for documentation of care including provider orders.
11. Establish a standardized approach across jurisdictions that facilitates statewide program evaluation using national guidelines for evaluation.
12. Require additional ongoing training reflecting the changing needs of the community or evolving health issues.

Introduction

The North Dakota Center for Nursing is a non-profit, 501c3 organization that was developed to represent over 17,000 nurses and 40+ nursing organizations across North Dakota. The mission of the North Dakota Center for Nursing is to guide the ongoing development of a well-prepared and diverse nursing workforce to meet the needs of the citizens of North Dakota through research, education, recruitment and retention, advocacy and public policy. This policy brief has been approved by our Board of Directors and is an official policy of the ND Center for Nursing.

The North Dakota Center for Nursing embraces innovative models to ensure safe and quality care. Every patient deserves access to safe, quality care from all healthcare providers. Health care delivery is ever-changing and is currently undergoing a significant transformation due to changes in the population and implementation of the Affordable Care Act. The North Dakota Center for Nursing supports initiatives which allow all members of the healthcare team to fully function consistent with their education and scope of practice as interprofessional partners.

Patient centered care coordination is a foundational element of nursing practice and is at the heart of nursing practice which makes nursing an integral partner of the health care team. The Institute of Medicine in 2003[1] emphasized the impact of coordination of care on improving the quality of care. In the Institute of Medicine 2011 report, this care coordination was cited as one of the traditional strengths of the nursing profession whether in the community or in the acute care setting[2].

The Community Paramedicine Program has the potential to operationalize the Institute for Healthcare Improvement Triple Aim[3] of decreasing healthcare costs, improving health outcomes and improving patient experiences. These outcomes should serve as the basis for program evaluation and provide the definition of success.

Certainly there are gaps in North Dakota's health care delivery system, especially in rural areas that new roles such as community paramedics could help fill.[5] However, careful consideration needs to be made in order to ensure quality and safe patient care within an interprofessional team of health care providers is provided. The National Consensus Conference on Community Paramedicine funded by the Agency for Healthcare Research and Quality (2012) explored the incorporation of community paramedics within the interdisciplinary health workforce environment. The study indicated that as standards of care and protocols evolve with increasingly interdependent roles between community paramedic providers and others in the healthcare system, it is necessary to determine the specific aspects of care for which community paramedic providers will be held accountable. The study recommended that successful integration of community paramedics will involve fulfilling six Cs[4]:

- *Community: addressing a current unfulfilled need;*
- *Complementary: enhancement without duplication;*
- *Collaborative: interdisciplinary practice;*
- *Competence: qualified practitioners ;*
- *Compassion: respect for individuals;*
- *Credentialed: legal authorization to function.*

Our policy recommendations are designed to help fulfill these and to help ensure that quality care is provided with no duplication of services to the citizens of North Dakota.

Policy Recommendations

1. **Through legislation during the 2015 session, develop a scope of practice to better define the community paramedic role and skill set and to include a provision for Advanced Practice Registered Nurses to also supervise community paramedics.** The current scope of practice (Century Code 33-36-04-02)[6] for a paramedic is focused on the provision of acute care and an interface with the hospital rather than the community setting. The Western Eagle County Health Services District in Colorado[7] indicated that it will be important to develop policies and procedures that provide explicit boundaries around the program.

2. **Require uniform education and training program including core components**. Uniform education and clinical training from an accredited program in the higher education setting consistent with the functions of the community paramedic role, should be required by state statue.[8] The American Nurses Association recommends that accredited educational programs should include core components from social and behavioral sciences and social determinants such as:

    1. *Cultural competency;*
    2. *Community roles and resources;*
    3. *Health Assessment;*
    4. *Personal Safety;*
    5. *Professional Boundaries*
    6. *Clinical components that include sub-acute and semi-chronic patient needs*

    The educational program should also include components on interprofessional role development such as role clarification, patient/client/family/ community centered care, team functioning, collaborative leadership, interprofessional communication and dealing with interprofessional conflict.[9] Currently, the pilot program has been utilizing the Hennepin Technical College Community Paramedic Program. It is not known whether this program includes all of the core components listed above.

3. **Define the referral process for each community paramedic program.** This includes how orders are transmitted between providers, the procedure for connecting patients with community paramedics, referring patients to other services and refusing care. Effective referral is important in maintaining continuity of care and are especially important for coordinating care between settings such as a hospital and a community.[8,10]

4. **Require community paramedics to utilize a community needs assessment to identify key focus areas for their work.** Community paramedics should utilize existing resources. The Western Eagle County Health Services District in Colorado[7] indicated that the community needs assessment can determine:

    - *The leading causes of preventable morbidity and mortality;*
    - *Gaps in health care services;*
    - *Demographics of the populations most impacted by the gaps;*
    - *Characteristics of those who most frequently use the ambulance service;*
    - *Most frequent conditions requiring hospital admission;*
    - *The greatest health care needs as seen by local medical providers;*

    Local public health units are experienced in conducting these assessments. All hospitals including Critical Access Hospitals have also conducted community needs assessments. The assessment would be used to customize the scope of the program to the needs of that community. Prior to implementation community paramedics should meet with key community partners including health care agencies, home health, public health, hospice and school health in each community in order to ensure coordination and no duplication of services. A written resource guide which includes available resources should be available for the community paramedic.

5. **Establish greater linkage and referral statewide for mental health and substance abuse services.** According to testimony by F-M Ambulance Service,[15] the primary reasons an ambulance is called for the top ten frequent users in the Fargo/Moorhead area are mental health issues (50%), diabetes complications (20%), seizures (20%) and substance abuse (10%). Greater linkage and referral is needed statewide for mental health and substance abuse services. An electronic, online, statewide directory of referrals for all health care providers to use within a team including but not limited to home health, faith/community nurses, public health, mental health, dentists, AA, substance abuse and recovery services should be developed to facilitate greater integration of services. The ND Behavioral Health Planning Final Report[16] also indicated the need to develop a one-stop-shop for behavioral health services in order to better track and improve access to services.

6. **Develop a realistic, sustainable funding model.** According to the Community Paramedic Study Background Memorandum prepared by Legislative Council[11], 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;*
    6. *School wellness and mid-level clinical services.*

    These potential services are very broad and in some cases require training beyond paramedic and community paramedic training and scope of practice (such as chronic disease management). The use of the term mid-level is inappropriate and outdated. The "call-a-nurse" service references a particular professional group and the title "nurse" is a protected title with a defined scope of practice and educational requirements. It is also unclear as to how these potential services, if linked with appropriate training and scope of practice changes, would become billable services and provide reimbursement for this program. Implementing this program is costly and is not fundable through a one-time payment.

7. **Provide limited short term services only if those services are not available in their geographic location or a patient doesn't qualify for home health, public health, hospice, school health or other resources.** Community paramedic services should not replace a patient's qualification for an existing services such as home health, public health, hospice and school health. Services by a community paramedic such as patient health assessments should only be offered if services are not available because the patient doesn't qualify for home health or the resources are not available in their geographical location. Services should be provided on a limited, short-term basis. Long term chronic disease management should be referred to other services. The Western Eagle County Health Services District in Colorado[7] indicated that in-home care that is delivered by a Community Paramedic is not of an ongoing nature (such as that provide by a home care agency), but rather each visit requires a discreet order from the patient's referring and/or primary care provider.

8. **Establish limited and short term/ emergent interventions paired with appropriate community paramedic training.** Community Paramedics can be relevant to both rural and urban areas, but these communities have different capabilities and different needs.[4] For example, the goal of the urban program is to reduce repeat ambulance/911 calls. The rural program revolves around filling gaps in health care delivery. The Western Eagle County Health Services District in Colorado[7] indicated that a different type of clinical training is needed depending on whether the Community Paramedics will provide in-home patient visits or community based services and that the services are within the legal scope of practice for paramedics. Possible community paramedic interventions include: [4]

    - *Home assessments (e.g. safety) ;*
    - *Patient resource needs assessments (e.g. food);*
    - *Assisting patients to manage their own healthcare (diabetes, CHF);*

- *Acute care response to reduce hospitalization;*
- *Supportive care for assisted living populations;*
- *Support for family caregivers;*
- *Post-discharge follow-up to prevent readmissions;*
- *Medication reconciliation and compliance;*
- *Behavioral health follow-up to increase attendance at appointments;*
- *Assessment with triage and referral.*

Specific protocols for Community Paramedics for each possible type of intervention should be developed using evidence based practice methods. Eagle County Paramedic Services has developed specific protocols for their Community Paramedics for each possible type of intervention within their system.[12]

9. **Through legislation during the 2015 session, include provider-neutral language in order to ensure that Advanced Practice Registered Nurses are able to supervise/delegate to community paramedics.** The American Association of Nurse Practitioners and the North Dakota Nurse Practitioner Association support the use of provider neutral langauge.[13] The Western Eagle County Health Services District in Colorado[7] also indicated the supervision and delegation to Community Paramedics may occur via physicians or advanced practice nurses.

10. **Through legislation during the 2015 session, provide clear definition and reporting lines for accountability and mechanism for documentation of care including provider orders.** Identify appropriate models for providing medical direction within varied Community Paramedic settings and services.[4] The Eagle County Community Program protocols manual included a medical direction and chain of command policy.[12] The chain of command should reflect provider-neutral language.

11. **Establish a standardized approach across jurisdictions to provide statewide program evaluation.** This approach should be developed by consensus of key stakeholders. This would allow for comparisons across the state. In addition to tracking decreased ER visits and hospital readmissions, evaluation should extend to include monitoring for outcomes, patient satisfaction and a decrease in adverse outcomes,[8] cost savings, compliance with medication regimens, attendance at appointments and information on patients that fall through gaps. The Western Eagle County Health Services District in Colorado[7] also indicated that the evaluation should include a method for tracking patients including the response times, percentage of uninsured, Medicaid and Medicare patients, age range, number of visits, leading types of chief complaints and leading outcomes of visits. The U.S. Department of Health and Human Services, Health Resources and Services Administration has developed an evaluation tool for Community Paramedicine programs.[14] The evaluation tool is designed to provide a common framework by which data can be collected from multiple Community Paramedicine programs and aggregated to provide a snapshot of common successes and challenges. The Agency for Healthcare Research and Quality National Consensus Conference on Community Paramedicine,[4] also indicated the need to for careful strategic evaluation. The North Dakota program should include these recommendations in designing its statewide program evaluation.

12. **Require additional ongoing training reflecting the changing needs of the community or evolving health issues.** With the prevalence of mental health and substance abuse calls cited in #5, community paramedics should also receive additional training such as Mental Health First Aid. This was also cited in the ND Behavioral Health Planning Final Report.[16] As additional issues are identified appropriate training should be developed.

In summary, the North Dakota Center for Nursing supports innovative models to ensure safe and quality care. Our policy recommendations are designed to ensure that successful implementation of the Community Paramedic program will result in every patient receiving safe, quality care through the coordinated effort of all health care providers.

References

1. Institute of Medicine (2003). Priority Areas for National Action: Transforming Health Care Quality. Website accessed 07/24/2013 http://iom.edu/Reports/2003/Priority-Areas-for-National-Action-Transforming-Health-Care-Quality.aspx

2. Institute of Medicine (2011) Future of Nursing: Leading Change, Advancing Health. Website accessed 07/24/2013 http://www.iom.edu/Reports/2010/the-future-of-nursing-leading-change-advancing-health.aspx

3. Institute for Healthcare Improvement Triple Aim Website accessed 07/24/2013 http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

4. Patterson, DG, Skillman, SM. (2013). National Consensus Conference on Community Paramedicine: Summary of an Expert Meeting. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; pages 6, 9, 23 quoted in brief. Website accessed 07/24/2014 http://depts.washington.edu/uwrhrc/uploads/CP_Report.pdf

5. Pearson, K., Gale, J., Shaler, G. (2014). Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program. Flex Monitoring Team Policy Brief #35. Website accessed 07/24/2014 http://www.flexmonitoring.org/publications/pb35/

6. ND Century Code Scope of Practice for Emergency Medical Services Professionals Website accessed 07/24/2014 http://www.legis.nd.gov/information/acdata/pdf/33-36-04.pdf?20140724160715

7. North Central EMS Institute. (2011). Western Eagle County Health Services District Community Paramedic Program Handbook. Website accessed 07/24/2014 http://communityparamedic.org/Program-Handbook

8. American Nurses Association (2014). ANA's Essential Principles for Utilization of Community Paramedics. Website accessed 07/24/2014 http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/ANAPrinciples/EssentialPrinciplies-UtilizationCommunityParamedics.pdf

9. Eisler, R. & Potter, T.M. (2014). Transforming Interprofessional Partnerships. Indianapolis, IN: Sigma Theta Tau International Honor Society of Nursing.

10. Edwards, N., Davies, B., Ploeg, J., Virani, T. & Skelly, J. (2007). Implementing Nursing Best Practice Guidelines: Impact on Patient Referrals. BMC Nursing, 6:4, p. 1-9. Website accessed 07/24/2014 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1947981/

11. North Dakota Legislative Council (2013). Community Paramedic Study: Background Memorandum. Website accessed 07/24/2014 http://www.legis.nd.gov/files/events/memorandum/15.9013.01000.pdf?20140724161809

12. Eagle County Paramedic Services (2013). Community Paramedic Protocols Manual.

    Website accessed 07/24/2014 http://ircp.info/Portals/11/Downloads/Tools/Eagle%20County%20Paramedics%20Community%20Paramedic%20Protocols.pdf

13. North Dakota Nurse Practitioners Association (2014). Report to Community Paramedic Stakeholders Meeting. Website accessed 07/24/2014 http://www.ndcenterfornursing.org/wp-content/uploads/2014/07/REPORT-TO-COMMUNITY-PARAMEDIC-STAKE-HOLDERS-MEETING-march-2014-final-draft.docx

14. U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy (2012). Community Paramedicine Evaluation Tool. Website accessed 07/24/2014 http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf

15. F-M Ambulance Service (2013). Testimony: Community Paramedic Study Senate Concurrent Resolution, No. 4002 Health Services Committee Website accessed 07/24/2014 http://www.legis.nd.gov/files/committees/63-2013nma/appendices/15_5038_03000appendixq.pdf?20140724162613

16. Schulte Consulting, LLC (2014). North Dakota Behavioral Health Planning Draft Final Report. Website accessed 07/24/2014 http://www.legis.nd.gov/files/committees/63-2013nma/appendices/15_5107_03000appendixb.pdf?20140724162912

#4

Mr. Chairman and Members of the Human Services Committee:

My name is Kristin Roers, and I am here on behalf of the North Dakota Nurses Association. NDNA remains neutral on SB 2043 as we believe that, to best serve the patient populations in the state of North Dakota, we need creative and flexible solutions, but would like to discuss some areas that we believe require additional clarification.

1. Provide a consistent standard for the services provided. Nursing has standards, medicine has standards – in healthcare, we are all accountable to protect the public. We believe a standard can be defined for Community Paramedics through the following:
    a. Define a scope of practice for the role
    b. Defining the appropriate licensure to perform this role
    c. Outlining a standardized training and education program
        i. Uniform education and clinical training from an accredited program in the higher education setting, consistent with the functions of the community paramedic role, should be required by state statute, rules, or regulations.

2. Community Paramedics can play an integral role in the interdisciplinary healthcare team. As nurses, we have been given the role of coordinators of patient care, so it is important that we are able to communicate and coordinate with CP's. Nursing would like to work alongside Community Paramedics to help to fill the gaps in our current healthcare delivery system. It is our hope that this coordination and communication will reduce role confusion and reduce duplication of services.

    We urge this Committee and the Department of Health to consider how to best coordinate the care provided by this new role in our system. It is our sincere hope that we can work together to provide care that is currently needed in our state.

In closing, we want this role to be legitimized and recognized in statute, but believe that some additional structure and regulation will be required for the role to function most effectively in our healthcare system.

Thank you for your time.

SB 2043
4-1-15

#1

A new subsection to section 50-24.6-04 of the North Dakota Century Code is created and enacted as follows:

The department may negotiate additional rebates from drug manufacturers to supplement the rebates required by federal law governing the medical assistance program."