Testimony
Interim Health Services Committee
October 30, 2013
North Dakota Department of Health

Good morning Chairwoman Lee and members of the Health Services Committee. I am Tim Wiedrich, Section Chief of the Emergency Preparedness and Response Section of the North Dakota Department of Health. I am here to provide information about the study as a result of Senate Concurrent Resolution 4002.

The concept of community paramedics, also known as Community Health Emergency Medical Services (EMS), is to use portions of the EMS workforce to address community health and medical needs that communities currently do not have the resources to address.

Nationally, using community paramedics to deliver basic primary care appears to offer unique opportunities to reduce emergency room contact and improve health outcomes for underserved patients. Both rural and urban models are emerging. Pilot projects are showing promising outcomes. A pilot program in Fort Worth, Texas, showed a 58 percent drop in ambulance calls and emergency department visits for enrolled patients and the decline estimated a health-care savings of close to 10 million dollars.

Many states are in the early phases of development like North Dakota. Challenges for states remain finding sustainable funding streams, defining scope of education and providing oversight. We anticipate the most difficult challenge will be the establishment of funding sources to sustain the community paramedic program through fees for service. We are paying particular attention to the success achieved in Minnesota. A bill passed last year in the Minnesota legislature established funding sources for that state's program through Medicaid. In February 2012, the federal Centers for Medicare and Medicaid Services (CMS) provided final approval to make community paramedic programs eligible for fee reimbursement in that state. Covered services in Minnesota include health assessments, immunizations, chronic disease monitoring and education, collection of lab specimens, medication compliance checks, hospital discharge follow-up care and minor medical procedures approved by a medical director. Minnesota, to our knowledge, is the first and only state that legislatively created a fee for service process for the community paramedic program.

Recently the federal government demonstrated additional interest when CMS provided a $9 million grant to the University of Reno, Nevada, and others to study

the health-care savings generated by implementing community paramedic programs.

North Dakota has been moving forward with the establishment of a community paramedic pilot program. The North Dakota Emergency Medical Services Advisory committee formed a Community Paramedic subcommittee about 18 months ago. Ken Reed is the new chair of the subcommittee replacing Ron Lawler. Mr. Reed is the only paramedic in the state who has attended and successfully completed a Community Paramedic training program. He will bring a great deal of knowledge and insight about the training and implementation of the program in North Dakota. He is the squad leader of the Rugby Ambulance Service. The next meeting of the subcommittee will be held in Bismarck on November 21, 2013.

Staff from the Division of Emergency Medical Services and Trauma (DEMST), along with assistance from the Community Paramedic subcommittee, are reviewing draft curricula from the North Central EMS Institute to determine if supplemental material will be needed. We currently believe likely enhancements to the curricula will be made in the areas of pharmacology, chronic disease management, geriatric care and worksite wellness.

DEMST staff are planning additional stakeholder consensus meetings. These meetings are targeted to be held in January 2014. DEMST staff are also planning implementation strategy for conducting the first Community Paramedic training program to be held in the state. The training is tentatively targeted for July 2014. Issues to be resolved for this training include the training venue and format; defining the roles of existing emergency medical services training institutions; and processes and locations for completing the appropriate clinic experience, including the number of patient contacts. Success in completing the appropriate clinical requirements will hinge on the support and participation of ambulance services with higher run volumes and active primary care providers.

DEMST staff are also developing evaluation metrics. These metrics are needed to assist in the evaluation of the success of the pilot project and the program. The metrics will need to be vetted with medical stakeholders and policymakers. We project completion and distribution of the vetted metrics by February 2014.

Thank you for your attention. I am happy to answer any questions you may have.