Community Paramedic Services

Health Services Medical Management

January, 2012

Legislative Report

Minnesota Department of **Human Services**

Contents

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Introduction

The concept of the Community Paramedic grows out of the traditional career ladder of Emergency Medical Technicians (EMTs). Most EMTs begin with a basic curriculum in emergency medicine and, over the course of a career, gain new skills and certifications through training. The typical ladder begins as a certified First Responder, then an Emergency Medical Technician – Basic (EMT-B), then an Emergency Medical Technician – Intermediate (EMT-I). Eventually, EMT's can obtain a certification to become an Emergency Medical Technician – Paramedic (EMT-P)[1].

The medical knowledge of a Paramedic is quite extensive. They are trained in evaluating an emergency situation and developing a plan to treat injuries and diseases of all major body systems and they can perform some intricate medical procedures. However, EMT professionals – including Paramedics – are not trained in primary care.

For the proponents of the Community Paramedic practice model, the goal is to apply and expand the skills learned by Paramedics into the domain of preventative, primary care medicine. The Community Paramedic could offer career Paramedics a new level of training and a new way to contribute their skills.

The Community Paramedic profession is in the beginning stages in Minnesota. There are only a handful of states with pilot projects underway. In most pilots, the model has been developed to address a specific, identified need or to extend care to a specific underserved population. At present, no state covers the services of Community Paramedics in a Medicaid program. In Minnesota, there is currently one course training Community Paramedics, with five students and eight graduates. There is no national or state standard list of services that defines the work of a Community Paramedic, no accepted scope of practice, and, to most advocates' knowledge, no time study has been performed to detail the individual tasks involved in a normal patient encounter.

[1] For this report, the term "Paramedic" refers to a certified Emergency Medical Technician – Paramedic as defined in MN Statute 144E.28.

Background

In 2011, the Legislature passed and Governor Dayton signed SF 119, creating a new certification for Community Paramedics. The law included language directing the Department of Human Services to create this report:

SF 119...

Sec. 3. COMMUNITY PARAMEDIC SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.

(a) The commissioner of human services, in consultation with representatives of emergency medical service providers, physicians, public health nurses, community health workers, and local public health agencies, shall determine specified services and payment rates for these services to be performed by community paramedics certified under Minnesota Statutes, section 144E.28, subdivision 9, to be covered by medical assistance under Minnesota Statutes, section 256B.0625. Services may include interventions intended to prevent avoidable ambulance transportation or hospital emergency department use, including the performance of minor medical procedures, initial assessments within the paramedic scope of practice, care coordination, diagnosis related to patient education, and the monitoring of chronic disease management directives in accordance with educational preparation.

(b) Payment for services provided by a community paramedic must be ordered by an ambulance medical director, must be part of a patient care plan that has been developed in coordination with the patient's primary physician and relevant local health care providers, and must be billed by an eligible medical assistance enrolled provider that employs or contracts with the community paramedic. In determining the community paramedic services to include under medical assistance coverage, the commissioner shall consider the potential of hospital admittance and emergency room utilization 3.1 reductions as well as increased access to quality care in rural communities.

(c) The commissioner shall submit the list of services to be covered by medical assistance to the chairs and ranking minority members of the senate Health and Human Services Budget and Policy Committee and the House of Representatives Health and Human Services Finance Committee by January 15, 2012. These services shall not be covered by medical assistance until further legislative action is taken.

DHS embarked on a process over the summer and fall of 2011 with the primary goal of describing the specific services that comprise the work of a Community Paramedic.

While the statute directs DHS to discuss specific rates for services, exact rate-setting takes place after a service is defined. To set rates for a defined service, DHS generally consults with stakeholders and performs a comparative analysis. For this report, DHS compiled information about rates and payment models for similar professions, so the stakeholders could get a sense of what reimbursement for Community Paramedics might be, given a range of similar services.

The Community Paramedic Statute stipulates that in order to obtain an Emergency Medical Technician -- Community Paramedic (EMT-CP) certificate, an applicant must, at a minimum, be certified as an Emergency Medical Technician – Paramedic (EMT-P) and have two years of full-time service.

The training for EMT-P focuses on emergency scenarios, but is extensive. The standard curriculum for EMT-P certification is included as Appendix A. Training includes instruction on interaction with other medical professionals, emergency interventions like CPR and oxygenation, collecting a medical history and physical exams, anatomy, basic pharmacology, and pathophysiological principles for major body systems.

Paramedics are trained to perform minor medical procedures such as minor suturing, intubation, and insertion of IVs, as well as the administration of pharmaceuticals – under the order and supervision of the ambulance medical director. Not every Paramedic can perform the same list of services. As part of their agreement with the medical director, the list of services each Paramedic can provide is approved by the medical director.

The statute also directs the Emergency Medical Services Regulatory Board (EMSRB) to enact the Community Paramedic certification process. At the time of writing this report, the EMSRB has approved the parameters of the certification and is implementing the process. In order to obtain a Community Paramedic certificate, an applicant will need to demonstrate successful completion of the EMT-P certification, prove that they worked as a Paramedic for at least two years, and submit a letter from their Medical Director.

Currently, the only course to train Community Paramedics in Minnesota is offered by Hennepin Technical College[2]. The course has produced 8 graduates and has 5 students. The Community Paramedic curriculum builds on the knowledge of the Paramedic, but focuses on prevention and community-based care. According to the course description,

"[t]he Community Paramedic program will respond to identified health needs in underserved communities, ultimately improving the quality of life and health of rural and remote citizens and visitors. Roles will include: Outreach; wellness; health screening assessments; health teaching; providing immunizations; disease management, including a thorough understanding of monitoring diabetes, congestive heart failure and other high cost diseases and the methods and medications used to treat them; recognition of mental health issues and referral into the existing mental health care system; wound care; safety programs; and, functioning as physician extenders in rural clinics and hospitals in communities that have them."

In addition to training in outreach and prevention strategies, the course includes a module on community assessment – to identify available medical, public health, and social services in the patient's community.

Nationally and internationally, there are a few recent projects where Community Paramedics are delivering care in a primary care setting. In most instances, care delivered by Community Paramedics is limited to a specific population, such as an isolated community, or those without access. The interventions (the list of service) in these models range from basic primary care to the management of a specific disease.

In 2003, in Nova Scotia, Canada[3], officials implemented a Community Paramedic model on two remote island communities with a population of 1200 who had no direct access to primary care. The only available medical care was in a hospital, nearly an hour away by ferry. In this model, care was coordinated between a Community Paramedic and, eventually, a Nurse Practitioner. The Community Paramedics lived on the islands and offered 24/7 emergency paramedic care, as well as basic primary care such as flu shots, routine tests, and fielding non-

[2] See: http://www.hennepintech.edu/customizedtraining/cts/44
[3] See: http://www.gov.ns.ca/health/ehs/documents/Community%20Paramedicine%20Article.pdf

emergency phone calls. The program served as many as 300 patients per month, and decreased hospital emergency visits by 23%.

In 2005, Eagle County, Colorado[4] implemented a Community Paramedic model to serve the 46% of county residents who were uninsured. The program is still operating, and data is forthcoming. Community Paramedics from the Western Eagle County Ambulance District receive orders from physicians for home visits. They deliver basic preventative care such as post-discharge follow-up, lab specimen collection, blood pressure checks, home safety inspections, social evaluations, and wound care.

In 2008, MedStar[5], a private EMS provider in Fort Worth, Texas began a Community Paramedic program. Hospitals analyzed ambulance run data to identify patients who used ambulance services a certain number of times. Recipients, who called an ambulance more than 10 times in an 18 month period of time, were enrolled in the program. Community Paramedics developed care plans for these patients and provided medical assessments, medication compliance, and social interaction. MedStar claims that the program has saved over $2.3 million since its inception.

DHS convened a workgroup to discuss the services that comprise the work of the Community Paramedic. The workgroup included representatives from organizations specified in the statute, as well as others with knowledge and interest in the concept. Members included representatives from:

- Minnesota Ambulance Association
- Community Health Care Emergency Cooperative
- Emergency Medical Services Regulatory Board (EMSRB)
- Minnesota Nurses Association
- Local Public Health Association
- Minnesota Community Health Worker Alliance
- Minnesota Home Care Association
- An ambulance service Medical Director
- The instructor of the Community Paramedic course
- Minnesota Department of Health, Office of Rural Health
- DHS, Health Services and Medical Management division

The workgroup met three times. In the first meeting, the discussion focused on the background of the Community Paramedic concept, and on the work currently being done by similar professions.

In order to obtain a Community Paramedic certification, an applicant must have at least two years of experience working as a certified Paramedic. The workgroup discussed the qualifications and training of a certified Paramedic. The nationally accepted curriculum is included as Appendix A. The curriculum represents a minimum, and individual Paramedics can perform more services or procedures if the Medical Director agrees and supervises.

The discussion of similar professions centered on a summary document put together by DHS, which is included as Appendix B. The document contains some basic information about scopes of practice for nurses, home care providers, social workers, physician assistants, and other professions that provide similar services. The analysis also included information about how the professions are supervised, and how the services are reimbursed by Medical Assistance.

[4] See: http://www.wecadems.com/cp.html
[5] See: http://www.medstar911.org/community-health-program

The second meeting included discussion about how Community Paramedics would be supervised, where the services could be delivered, and finally, the services themselves.

Supervision of all EMT professions, including Paramedics and Community Paramedics, is the responsibility of the Medical Director of the ambulance service. A Medical Director must be a physician; certified EMTs work under the Medical Director's license. The Medical Director is responsible for the care delivered, for approving the list of services each EMT is allowed to provide, and for billing such services.

Medical Directors may occasionally serve as a patient's family physician as well as supervise care during an emergency transport, but in most cases the Medical Director does not see patients in a primary care setting. Duplication of services may be a concern if the Community Paramedic's services are not coordinated with a patient's existing primary care. The workgroup discussed the option of requiring an order for Community Paramedic services from a primary care physician, and agreed that such a requirement would be appropriate.

The workgroup also discussed the likely places of service where Community Paramedics would deliver care. The patient's home or residence would be a natural place for Community Paramedics to deliver care, but proponents also discussed how the services could be appropriate in other health care settings. Hospitals, clinics, and residential facilities were discussed. The proponents also mentioned that Paramedics are frequently called to nursing homes to perform minor medical procedures that nursing home staff cannot perform, or where staffing is inadequate.

Finally, the workgroup went through a free-form discussion to list all the services that a Community Paramedic could provide, based on their training and skills. The list included many types of care, including primary care, dental, and mental health services. The workgroup was then asked to narrow down the broader list to the services that should be included in this report. The final list is as follows:

Community Paramedic Services

- Treat, no transfer
- [This means the Community Paramedic could perform necessary emergency services on site, without requiring a transport to a medical facility.]
- Minor medical procedures, including:
- Minor suturing
- Feeding tube insertion
- Catheter replacement
- Tracheostomy tube replacement
- Wound care
- Fluid replacement
- Laboratory services, including:
- Lab specimen collection
- Blood draws
- Assess and refer, including:
- Injury risk assessment / home safety assessment
- Oral health assessment
- Mental health assessment
- Fall prevention
- Ear, Nose, and Throat (ENT) assessment

- Social evaluation
- Chronic disease care, including:
- Congestive Heart Failure
- Diabetes care
- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Asthma
- Stroke
- Clinical care, including:
- 12-lead EKGs
- Respiratory services
- Care plan follow-up
- Hospital discharge follow-up
- Immunizations / vaccinations
- Medication compliance
- Medication administration

Conclusion

According to the statute, the Legislature must take further action to define the services of a Community Paramedic before the service can be covered by Medical Assistance. Assuming that action proceeds, DHS would then set a rate for the service based on the defined services. There are multiple options for reimbursement, including a flat rate per unit delivered, or a tiered payment model to account for variation in the complexity of patient encounters. Reimbursement methods will also depend on how the services can be described under the standard billing codes and the impact of other uniform billing requirements under federal and state law. Additionally, DHS must consider how these providers align with other physician extenders whose services are paid under the state's Medical Assistance program.

The effect of extending coverage to Community Paramedics would be small at first. There are only a handful of trained individuals who could provide the service. The likely effect on the state budget initially would be minimal. Proponents claim potential savings are likely, but there is little applicable data available. Most pilot programs for Community Paramedics plug the service into an identified gap in access or coverage. Medical Assistance enrollees already have access to the services provided by all the professions described in Appendix B, as well as others.

The workgroup has been helpful in seeking definition for the services a Community Paramedic could provide, and that could be covered in Medical Assistance. More should be done to add specificity. Proponents could embark on a formal process to define the services more clearly including establishing uniform billing guidance. A time study to detail the tasks involved with a standard patient encounter would help in the rate-setting process.

Moving forward, there are a few options that would let the profession continue to develop and meet identified needs in the community.

- ***Approve coverage in Medical Assistance and seek Federal Financial Participation***

If approved by the Legislature, DHS would embark on the formal process to seek federal approval of Community Paramedic services in the Minnesota Medicaid State Plan. This option would require DHS, prior to seeking federal approval, to work with the stakeholders to establish the scope of services, uniform billing standards, and rate methodology.

- ***Approve coverage in Medical Assistance and fund with state-only dollars***

If DHS does not or cannot obtain federal approval of Community Paramedic services in the Minnesota Medicaid State Plan, an option would be to fund the service using state-only dollars. This option still requires DHS to undertake the steps noted above, but would not require federal approval.

- ***A pilot program***

A pilot program would allow the existing Community Paramedics to integrate their services in the primary care system of a single community where a specific need has been identified. It would also allow time to more clearly define the services and to perform a time study to quantify the exact tasks involved with this service. A pilot program, once identified, could be funded with state dollars, or from a private source. The scope of services would be defined as part of the pilot project, along with the evaluation components necessary to analyze the impact and costs.

Appendix A

DHS Community Paramedic Workgroup
EMT-P Standard Curriculum
Copied from http://www.ems.gov/pdf/NSCparamedic1998.pdf , on October 13, 2011

EMT-Paramedic: National Standard Curriculum

Module and Unit Objective Summary

1 At the completion of this module, the paramedic student will understand the roles and responsibilities of a Paramedic within an EMS system, apply the basic concepts of development, pathophysiology and pharmacology to assessment and management of emergency patients, be able to properly administer medications, and communicate effectively with patients.

1-1 At the completion of this unit, the paramedic student will understand his or her roles and responsibilities within an EMS system, and how these roles and responsibilities differ from other levels of providers.
1-2 At the completion of this unit, the paramedic student will understand and value the importance of personal wellness in EMS and serve as a healthy role model for peers.
1-3 At the completion of this unit, the paramedic student will be able to integrate the implementation of primary injury prevention activities as an effective way to reduce death, disabilities and health care costs.
1-4 At the completion of this unit, the paramedic student will understand the legal issues that impact decisions made in the out-of-hospital environment.
1-5 At the completion of this unit, the paramedic student will understand the role that ethics plays in decision making in the out-of-hospital environment.
1-6 At the completion of this unit, the paramedic student will be able to apply the general concepts of pathophysiology for the assessment and management of emergency patients.
1-7 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles of pharmacology and the assessment findings to formulate a field impression and implement a pharmacologic management plan.
1-8 At the completion of this unit, the paramedic student will be able to safely and precisely access the venous circulation and administer medications.
1-9 At the completion of this unit, the paramedic student will be able to integrate the principles of therapeutic communication to effectively communicate with any patient while providing care.
1-10 At the completion of this unit, the paramedic student will be able to integrate the physiological, psychological, and sociological changes throughout human development with assessment and communication strategies for patients of all ages.

2 At the completion of this module, the paramedic student will be able to establish and/or maintain a patent airway, oxygenate, and ventilate a patient.

2-1 At the completion of this unit, the paramedic student will be able to establish and/or maintain a patent airway, oxygenate, and ventilate a patient.

3 At the completion of this module, the paramedic student will be able to take a proper history and perform a comprehensive physical exam on any patient, and communicate the findings to others.

3-1 At the completion of this unit, the paramedic student will be able to use the appropriate techniques to obtain a medical history from a patient.
3-2 At the completion end of this unit, the paramedic student will be able to explain the pathophysiological significance of physical exam findings.
3-3 At the end of this unit, the paramedic student will be able to integrate the principles of history taking and techniques of physical exam to perform a patient assessment.

3-4 At the end of this unit, the paramedic student will be able to apply a process of clinical decision making to use the assessment findings to help form a field impression.
3-5 At the completion of this unit, the paramedic student will be able to follow an accepted format for dissemination of patient information in verbal form, either in person or over the radio.
3-6 At the completion of this unit, the paramedic student will be able to effectively document the essential elements of patient assessment, care and transport.

4 At the completion of this module, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the trauma patient.

4-1 At the completion of this unit, the Paramedic student will be able to integrate the principles of kinematics to enhance the patient assessment and predict the likelihood of injuries based on the patient's mechanism of injury.
4-2 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the patient with shock or hemorrhage.
4-3 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and the assessment findings to formulate a field impression and implement the treatment plan for the patient with soft tissue trauma.
4-4 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and the assessment findings to formulate a field impression and implement the management plan for the patient with a burn injury.
4-5 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and the assessment findings to formulate a field impression and implement a treatment plan for the trauma patient with a suspected head injury.
4-6 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and the assessment findings to formulate a field impression and implement a treatment plan for the patient with a suspected spinal injury.
4-7 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and the assessment findings to formulate a field impression and implement a treatment plan for a patient with a thoracic injury.
4-8 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and the assessment findings to formulate a field impression and implement the treatment plan for the patient with suspected abdominal trauma.
4-9 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and the assessment findings to formulate a field impression and implement the treatment plan for the patient with a musculoskeletal injury.

5 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the medical patient.

5-1 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the patient with respiratory problems.
5-2 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the patient with cardiovascular disease.
5-3 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the patient with a neurological problem.
5-4 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement a treatment plan for the patient with an endocrine problem.

5-5 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement a treatment plan for the patient with an allergic or anaphylactic reaction.
5-6 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the patient with a gastroenterological problem.
5-7 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and the assessment findings to formulate a field impression and implement a treatment plan for the patient with a renal or urologic problem.
5-8 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement a treatment plan for the patient with a toxic exposure.
5-9 At the completion of this unit, the paramedic student will be able to integrate the pathophysiological principles of the hematopoietic system to formulate a field impression and implement a treatment plan.
5-10 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the patient with an environmentally induced or exacerbated medical or traumatic condition.
5-11 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement a management plan for the patient with infectious and communicable diseases.
5-12 At the end of this unit, the paramedic student will be able to describe and demonstrate safe, empathetic competence in caring for patients with behavioral emergencies.
5-13 At the end of this unit, the paramedic student will be able to utilize gynecological principles and assessment findings to formulate a field impression and implement the management plan for the patient experiencing a gynecological emergency.
5-14 At the completion of this unit, the paramedic student will be able to apply an understanding of the anatomy and physiology of the female reproductive system to the assessment and management of a patient experiencing normal or abnormal labor.

6 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for neonatal, pediatric, and geriatric patients, diverse patients, and chronically ill patients.

6-1 At the completion of this lesson, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the neonatal patient.
6-2 At the completion of this lesson, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the pediatric patient.
6-3 At the completion of this unit, the paramedic student will be able to integrate the pathophysiological principles and the assessment findings to formulate and implement a treatment plan for the geriatric patient.
6-4 At the completion of this unit, the paramedic student will be able to integrate the assessment findings to formulate a field impression and implement a treatment plan for the patient who has sustained abuse or assault.
6-5 At the completion of this unit the paramedic student will be able to integrate pathophysiological and psychosocial principles to adapt the assessment and treatment plan for diverse patients and those who face physical, mental, social and financial challenges.
6-6 At the completion of this unit, the paramedic student will be able to integrate the pathophysiological principles and the assessment findings to formulate a field impression and implement a treatment plan for the acute deterioration of a chronic care patient.

7 At the completion of this unit, the paramedic student will be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for patients with common complaints.

7 -1 At the completion of this unit, the paramedic student will be able to integrate the principles of assessment based management to perform an appropriate assessment and implement the management plan for patients with common complaints.

8 At the completion of this unit, the paramedic student will be able to safely manage the scene of an emergency.

8-1 At the completion of this unit, the paramedic will understand standards and guidelines that help ensure safe and effective ground and air medical transport.

8-2 At the completion of this unit, the paramedic student will be able to integrate the principles of general incident management and multiple casualty incident (Mel) management techniques in order to function effectively at major incidents.

8-3 At the completion of this unit, the paramedic student will be able to integrate the principles of rescue awareness and operations to safely rescue a patient from water, hazardous atmospheres, trenches, highways, and hazardous terrain.

8-4 At the completion of this unit, the paramedic student will be able to evaluate hazardous materials emergencies, call for appropriate resources, and work in the cold zone.

8-5 At the completion of this unit, the paramedic student will have an awareness of the human hazard of crime and violence and the safe operation at crime scenes and other emergencies.

Appendix B

LOCAL PUBLIC HEALTH ASSOCIATION OF MINNESOTA

January 12, 2012

Mr. Will Wilson
Minnesota Department of Human Services
540 Cedar Street
St Paul, Minnesota 55101

Dear Mr. Wilson:

The Local Public Health Association (LPHA) represents city, county and tribal public health departments in Minnesota and works statewide to improve and protect the health of Minnesotans. We appreciate the opportunity to participate in the Department of Human Services work group convened to develop a report the Legislature on potential covered services for Community Paramedics as defined by Minnesota Statute section 144E.28, subdivision 9.

While the concept of the Community Paramedic is not new, it is new to the State of Minnesota. It is possible to see the benefits the community paramedic concept could bring to a community and we understand the desire to use this resource more effectively or risk losing it.

However, the LPHA and its members have concerns about how this may impact other resources currently available in the community. As you know, Minnesota has a rich history of community coordination and local public health departments, along with many other partners, share this responsibility. We feel it is critical that this new resource be folded into the current structures and processes that exist in each community.

All local public health departments are required by law to conduct community health assessments for their county/city. Part of that assessment includes looking at gaps and needed services for their jurisdiction. They assess what resources exist and which resources either need to be developed or connected to assure better coordination across the local system. We feel it is vital that the community paramedic resource intersect (and avoid duplication) with this process to help identify where community paramedics may, or may not, fit into the needs of the community.

In addition, health care homes are being developed and implemented across Minnesota and are designed to reduce health care costs by coordinating services for clients. The development of health care homes is already underway and we feel it will be important to fold the development of a community paramedic program into this structure. The statute clearly intended for this to happen and we would like to stress the importance of this being part of the implementation of this new program.

While a medical director of a service has the authority to "order" services for a client, the primary care provider has responsibility for the care of that client and health care homes supports this concept.

Our ultimate desire is to assure this new resource fulfills the intent of the statute to ensure "there is no duplication of services to the patient" but also that we avoid duplication of the service to a community. Blending this program into the structures or processes already in place will help to prevent these costly inefficiencies.

It is clear that there are great needs in each community but it is our hope that Minnesota structures the community paramedic program to help meet gaps where they are identified. That will help assure success for not only this program but also help support stronger and healthier communities.

Sincerely,

Elizabeth Auch

Elizabeth Auch, PHN
Countryside Public Health Administrator
Local Public Health Association Chairperson

Minnesota Nurses Association
An Affiliate of National Nurses United

Date: December 15, 2011

To: Senator Hann, Chair of Senate Health and Human Services Budget and Policy Committee
Representative Abeler, Chair of Health and Human Services Finance Committee

From: Minnesota Nurses Association

RE: Community Paramedic

First and foremost, the Minnesota Nurses Association firmly believes in guaranteed Health Care for all, including coverage and access. Nurses are professionally and legally bound and ethically responsible to advocate and make every effort to protect the safety, health and rights of the patients.

The MN Nurses Association is appreciative for the opportunity to participate in the workgroup however we remain opposed to this role, the Community Paramedic. We are concerned about continuity of care, ambiguity in services provided and consumer safety in this care model.

Many inconsistencies remain in the execution of this role/provider, which is why we oppose the Community Paramedic, (CP).

1) The list of services which may be considered for reimbursement for MA is very broad. The conclusion is far reaching and expansive because it is unclear what problem this role is attempting to solve/fill. The original questions remain. Will the CP be a provider to get those in need of health care, access to care? Will it be for communities to better serve their area with experienced health care providers who have "down time"? Will it be to assist in Nursing Homes across the state to avoid unnecessary emergency room visits? Will it decrease all ED visits? It is for this lack of clarity, that the MN Nurses Association cannot support it.
2) As stated in the DHS report, all persons on MA already have access to all providers who cover the list of services that could be provided by a community paramedic. This begs the question, "Do we need another new public health care provider, or do we need more of the ones we already have who are trained and in the MN Health Care System?"
3) The MN Nurses concerns reach beyond the list of services and the work of this workgroup which were expressed in the 20111egislative session. As you continue to discuss and debate the community paramedic role in 2012 the nurses ask that you keep these issues in the forefront.

Professional Distinction

Personal Dignity Patient

Advocacy

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Suite 200
St. Paul, MN 55102
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Email: mnnurses@mnnurses.org
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AFL-CIO

a. Medical Licenses and nursing licenses are not interchangeable. A medical director shall not supervise, delegate or evaluate nursing care. By allowing the medical director to direct a CP to do many of these services outside of an emergent situation, is allowing a medical director to practice nursing without a nursing license.
According to the Nurse Practice Act, only a professional registered nurse may delegate nursing care and supervise nursing care.

b. The law amends MN statute section 2568.0625 as it allows a CP "to perform initial assessments within their scope of practice". According to MN Statute, in order to have a scope of practice one must have a license. This law cannot create licensure for paramedics. So to refer to a scope of practice is inconsistent with current law.

4) Finally, without any coordination or planning it appears to be creating a parallel Public Health System without synchronization into the Health Care Home.

Sincerely,

Linda Hamilton RN. BSN

Linda Hamilton, RN
President, Minnesota Nurses Association

Cc: Commissioner of Human Services, Lucinda Jesson
Commissioner of Health, Ed Ellinger

Appendix C

DHS Community Paramedic Workgroup
Comparison Chart of Similar Professions
October 19, 2011

Profession	License/Certification	Scope of Practice / Skills	Supervision	Notes	Statute(s)
Nursing	Licensed Practical Nurse (LPN)	May observe or care for patients and administer treatments that do not require the specialized education, knowledge, or skill of an RN.	Supervised by RN, APRN, Physician, Dentist, et al		MS 148.171 -285
Nursing	Registered Nurse (RN)	May assess health needs of patients, provide skilled nursing care, supervise and teach nursing personnel, conduct case finding and referral	Includes both independent and delegated medical functions performed with other team members. RNs may delegate to others	Registered Nurse, Certified -- not eligible to enroll as DHS providers	MS 148.171 -285
Nursing	Advanced Practice Registered Nurse (APRN) Includes: • Nurse Practitioner • Clinical Nurse Specialist • Registered Nurse Anesthetist • Nurse Midwife	May engage in direct care, case management, consultation, education or research, and accept referrals from other health care providers May prescribe drugs and therapeutic devices under a written agreement with a physician	Must work in a collaborative agreement with a physician in the same specialty	DHS enrolls all APRNs who choose to. APRNs who do not to enroll with DHS can be paid as Physician Extenders, at 65% of the physician rate.	MS 148.171 -285
Home Care	Home Health Aide	Medically-oriented tasks written in the	RN, or appropriate	HHA services	MN Rule

Profession	License/Certification	Scope of Practice / Skills	Supervision	Notes	Statute(s)
Services	(certification)	recipient's plan of care: Hands-on personal care, simple procedures as an extension of therapy or nursing services, and IADLs, if identified in the written plan of care.	therapist when providing services that are an extension of therapy	require authorization and are reviewed for medical necessity	9505.0290
Home Care Services	Personal Care Attendant (DHS training, test)	Covered Services include: • Activities of Daily Living (ADLs): dressing; grooming; bathing; eating; transfers; mobility; positioning; toileting • Delegated health-related procedures and tasks • Observation and redirection of behaviors • Instrumental Activities of Daily Living (IADLs): accompanying to medical appointments or to community functions; assistance with paying bills; completion of household tasks; preparation of meals; shopping for food, clothing, and essential items.	By a Qualified Professional. Must be employed by an enrolled PCA provider agency. Health-related procedures must be supervised by a nurse	PCA services require authorization and are reviewed for medical necessity	MS 245A
Home Care Services	Skilled Nursing Visit (RN, LPN)	A Skilled nursing visit is a nurse visit to initiate and complete a professional nursing task as assessed to meet the person's need in his or her home. A Skilled nursing visit can include the following services: • Hands on nursing care • Health care training to the consumer	Only a registered nurse or a licensed practical nurse employed by a Medicare-certified agency may provide this service	SNV services require authorization and are reviewed for medical necessity	256B.0625

Profession	License/Certification	Scope of Practice / Skills	Supervision	Notes	Statute(s)
		and/or their family • Observation and assessment of the consumer's physical status			
Home Care Services	Private Duty Nursing (RN, LPN)	More extensive than a Skilled Nursing Visit, and can include: • Professional Nursing care based on an assessment of the consumer's medical needs • Ongoing professional nursing observation, monitoring, intervention, and evaluation	• A registered nurse (RN) or licensed practical nurse (LPN) employed by either a home health agency or PDN Class A licensed agency enrolled with DHS • An independent RN enrolled w/DHS. • An independent LPN with a Class A license, enrolled with DHS.	PDN services require authorization and are reviewed for medical necessity	MN Rule 9505.0360
Social Work	Licensed Social Worker	Definition of Social Work practice: "...working to maintain, restore, or improve behavioral, cognitive, emotional, mental, or social functioning of clients, in a manner that applies accepted professional social work knowledge, skills, and values, including the person-in-environment perspective, by providing in person or through telephone, video conferencing, or electronic means... ...Providing assessment and intervention through direct contact with clients, developing	None required		MS 148E.055

Profession	License/Certification	Scope of Practice / Skills	Supervision	Notes	Statute(s)
		a plan based on information from an assessment, and providing services which include, but are not limited to, assessment, case management, client-centered advocacy, client education, consultation, counseling, crisis intervention, and referral"			
Social Work	Licensed Graduate Social Worker	Social Work practice, master's-level	None required		MS 148E.055
Social Work	Licensed Independent Social Worker	Social Work practice, plus Clinical practice: "applying professional social work knowledge, skills, and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders. Treatment includes a plan based on a differential diagnosis. Treatment may include, but is not limited to, the provision of psychotherapy to individuals, couples, families, and groups."	100 hours per 4000 hours of practice, by a supervising Social Worker		MS 148E.055
Social Work	Licensed Independent Clinical Social Worker	Social Work practice, plus Clinical practice, plus 360 hours in clinical knowledge areas	200 hours per 4000 hours of practice, by a supervising Social Worker	Enrolled as DHS providers,	MS 148E.055
Physician Assistant	Current certification from the National Commission on Certification of Physician Assistants	Orders of PAs shall be considered the orders of their supervising physicians in all practice-related activities, including, but not limited to, the ordering of diagnostic, therapeutic, and other medical services.	Patient service must be limited to: • services customary to the practice of the supervising physician	Not enrolled as DHS providers, paid at 90% of physician rate. Billed using the physician's NPI,	M.S. 147A

Profession	License/Certification	Scope of Practice / Skills	Supervision	Notes	Statute(s)
		The supervising physician may delegate the following to the PA: • services within the training and experience of the physician assistant; • taking patient histories and developing medical status reports; • performing physical examinations; • interpreting and evaluating patient data; • ordering or performing diagnostic procedures, • ordering or performing therapeutic procedures • providing instructions regarding patient care, disease prevention, and health promotion; • assisting the supervising physician in patient care in the home and in health care facilities; • creating and maintaining appropriate patient records; • transmitting or executing specific orders at the direction of the supervising physician; • prescribing, administering, and dispensing drugs, controlled substances, and medical devices if this function has been delegated by the supervising physician • for physician assistants not delegated prescribing authority, administering legend drugs and medical devices following	or alternate supervising physician; • services delegated by the supervising physician or alternate supervising physician under the physician-physician assistant delegation agreement; and • services within the parameters of the laws, rules, and standards of the facilities in which the physician assistant practices.	with a modifier to indicate PA provided the care	

Profession	License/Certification	Scope of Practice / Skills	Supervision	Notes	Statute(s)
		prospective review for each patient by and upon direction of the supervising physician; • functioning as an emergency medical technician with permission of the ambulance service and in compliance with section 144E.127, and ambulance service rules adopted by the commissioner of health; • initiating evaluation and treatment procedures essential to providing an appropriate response to emergency situations; • assisting at surgery; and • providing medical authorization for admission for emergency care and treatment of a patient under section 253B.05, subdivision 2.			
Care Coordinator, Health Care Home	None, can be any health care professional	Care Coordinator Services defined by a care plan, developed in a team-based process including the patient/patient's family.	Direct supervision by physician	Services paid to Health Care Home as a per member/per month Care Coordination Fee	MN Rule 4764.0040
Community Health Worker (CHW)	Completion of certificate course from NMSCU or accredited institution	Diagnosis-related patient health education in the client's cultural context	Services must be ordered by MD, APRN, Certified Public Health Nurse, or Dentist	CHWs must be enrolled with DHS as non-billing providers	MS 256B.0625

Profession	License/Certification	Scope of Practice / Skills	Supervision	Notes	Statute(s)
Physician Extender (PE)	A Physician Extender can be: • Physician Assistant or APRN who does not enroll w/DHS • RN • Genetic counselor • Licensed acupuncturist • Pharmacist	PEs may provide any service within their scope of practice and as delegated and directed by a physician. The plan of care for a condition other than an emergency may be developed by the PE, but must be reviewed, approved and signed by the physician before care is begun The PE may carry out the treatment, but the physician must review and countersign the record of a treatment within 5 working days after the treatment The diagnosis must be made by or reviewed, approved, and signed by the physician	A PE must be: • Supervised by a physician • Employed by the physician, or • Employed by the same provider organization that employs the physician Physician must be present, available, and on the premises more than 50% of the time while PE is delivering services	Billed using the physician's NPI, with a modifier to indicate PE provided the care	
EMT	EMT Certification	Pre-hospital protocol, as established by medical director	Work under the license of the Medical Director		MS 144E.001
EMT	EMT-Intermediate Certification	Pre-hospital protocol, as established by medical director	Work under the license of the Medical Director		MS 144E.001
EMT	EMT-Paramedic Certification	Pre-hospital protocol, as established by medical director (See HANDOUT)	Work under the license of the Medical Director		MS 144E.001