Community Paramedic
The Minnesota Experience

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Minnesota's early CP experience

- Started nearly 15 years ago as a result of initiatives like the Red River Project.
- Gary Wingrove (Gold Cross Ambulance) suggested CP concept as a means to fill unmet needs in underserved, primarily rural areas of Minnesota.
- Meetings were held with key state elected officials. Initially received a cool reception.
- CP concept received some support from the office of rural health and primary care to establish a curriculum and begin a pilot project with the Mdewakanton Sioux Health Services.

Key Obstacles for CP acceptance

- CP not an easily understood proposal to solve the initially rural health care shortage issue.
- Tough to sell a concept that the “sellers” cannot clearly articulate.
- No defined curriculum, clinical or testing standards early on in the CP concept.
- Early on as we discussed CP around the health care community setting. Opposition expanded as “perceived competition” for other jobs in health care grew.
- Last, elected officials (and the public in general) lacked any understanding of paramedic services, the training and patient care involved.

The Gaps in health began to happen

- Over the subsequent decade, gaps in health care services were increasingly brought forward to elected representatives and numerous health care committees were established.
- They were tasked with identifying needs in geographic areas where significant gaps existed.
- Governors task force on health care reform to address a major shortfall in state health care dollars.
- These above work groups began to change the dynamics at the state legislature as elected officials struggled with addressing increased demand, limited government dollars and political opposition to change.

Integrating CP's into the system

- Over the next few years we began to talk about an expanded role for advanced paramedics in Minnesota with whomever would listen.
- Discussed how CP's could fill a role in treatment gaps, reducing the cost of overall health care expenditures by preventing unnecessary,costly paramedic service's, reducing stress on vulnerable patients and hospital emergency dept utilization.
- However we had still not developed a clear, concise proposal for integration of CPs into the health care system.

Putting Community Medic into law

- Over the next few years the treatment and access gaps continued to grow and the legislature continued to reach out for ideas.
- Lack of legislative action and public pressure for solutions began to create an environment in which reform and innovation was accepted.
- Hospitals in Minnesota began to form new relationships with both state and federal payers around “total cost of care” and “shared savings”.
- In 2010 we began to receive warmer support for the CP program. Meetings were held at the Capitol to discuss our concept but we still lacked details.

Drafting the first CP legislation

- Realizing the need for a clear concise proposal which represented at least a partial solution we embarked on a draft piece of legislation.
- Our initial legislation focused on addressing the growing frustration of policy makers to help control cost.
- We quickly realized that even our advocates failed to have acceptable answers to questions raised inside our own ambulance association. We decided not to proceed with legislation for the 2010 session.
- We felt we needed to know the questions as well as the answers before they are even asked to move legislation of this magnitude.

Sprinting through a forest blindfolded

- Prior to the commencement of the 2011 legislative session we drafted CP legislation to share with other health care providers.
- We also outlined a clear political strategy to ensure legislative success.
- We tried to identify all our supporters and possible opponents.
- Our biggest challenge was that no other jurisdiction in the United States had enacted such language for CP.
- Our CP enabling legislation underwent 19 drafts after input from every group imaginable. Most importantly we recognized the need for improving the language as the process unfolded.

A bill for an act

relating to human services; creating a certification for community paramedics; amending Minnesota Statutes 2010, sections 144E.001, by adding a subdivision; 144E.28, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2010, section 144E.001, is amended by adding a subdivision to read:

Subd. 5f. **Emergency medical technician-community paramedic or EMT-CP.** "Emergency medical technician-community paramedic," "EMT-CP," or "community paramedic" means a person who is certified as an EMT-P and who meets the requirements for additional certification as an EMT-CP as specified in section 144E.28, subdivision 9.

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 2. Minnesota Statutes 2010, section 144E.28, is amended by adding a subdivision to read:

Subd. 9. **Community paramedics.** (a) To be eligible for certification by the board as an EMT-CP, an individual shall:

(1) be currently certified as an EMT-P, and have two years of full-time service as an EMT-P, or its part-time equivalent;

(2) successfully complete a community paramedic training program from a college or university that has been approved by the board or accredited by a board-approved national accreditation organization. The training program must include clinical experience that is provided under the supervision of an ambulance medical director, advanced practice registered nurse, physician assistant, or public health nurse operating under the direct authority of a local unit of government; and

(3) complete a board-approved application form.

(b) A community paramedic must practice in accordance with protocols and supervisory standards established by an ambulance service medical director in accordance with section 144E.265. A community paramedic may provide services as directed by a patient care plan if the plan has been developed by the patient's primary physician or by an advanced practice registered nurse or a physician assistant, in conjunction with the ambulance service medical director and relevant local health care providers. The care plan must ensure that the services provided by the community paramedic are consistent with the services offered by the patient's health care home, if one exists, that the patient receives the necessary services, and that there is no duplication of services to the patient.

(c) A community paramedic is subject to all certification, disciplinary, complaint, and other regulatory requirements that apply to EMT-Ps under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2011.

Passing the 2011 CP legislation

- We continued to work full-time neutralizing opposition based off of 40 years of state government experience between us.
- We enjoy a positive reputation at the legislature and state agencies working in the past on ambulance and health care issues.
- Good relationships are the key to making the wheels of government turn and helps in securing passage of state laws.
- We identified the creative, problem solvers with interest in patient care who would consider a new approach to recurring problems. Policy makers who understood the changes coming to health care in delivery and payment models.

Closing the deal with all parties

- Held meetings with public officials responsible for enacting the state budget and discussed savings.
- Held meetings and received support from health plans that primarily cover government programs.
- Discussed and used examples from other states and countries pilot project savings.
- Also worked closely with policy makers who support paramedic services.
- All lawmaking bodies regardless of what country or jurisdiction,have people in positions of leadership. We have positive relationships within our legislative leadership and the Governor’s Office.

2012 legislation the payment model

- Our second initiative after passing the enabling and certification language in 2011 was to pass the payment language.
- After all the ground work we did in 2011 we found the payment language to be more manageable. Opponents continued to be the Nurses Association and Home Health Association.
- Once again we had strong legislative authors to work with the state department of human services on a payment model.
- We felt if CP was going to move forward in MN we needed to go away from pilots and implement the service.
- After only two drafts of the legislation and working with the nurses and home health association no one opposed our legislation.

A bill for an act

relating to human services; providing medical assistance coverage for community paramedic services; amending Minnesota Statutes 2010, section 256B.0625, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 60. **Community paramedic services.** (a) Medical assistance covers services provided by community paramedics who are certified under section 144E.28, subdivision 9, when the services are provided in accordance with this subdivision to an eligible recipient as defined in paragraph (b).

(b) For purposes of this subdivision, an eligible recipient is defined as an individual who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an individual who has been identified by the individual's primary health care provider for whom community paramedic services identified in paragraph (c) would likely prevent admission to or would allow discharge from a nursing facility; or would likely prevent readmission to a hospital or nursing facility.

(c) Payment for services provided by a community paramedic under this subdivision must be a part of a care plan ordered by a primary health care provider in consultation with the medical director of an ambulance service and must be billed by an eligible provider enrolled in medical assistance that employs or contracts with the community paramedic. The care plan must ensure that the services provided by a community paramedic are coordinated with other community health providers and local public health agencies and compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director.

(d) Services provided by a community paramedic to an eligible recipient who is also receiving care coordination services must be in consultation with the providers of the recipient's care coordination services.

(e) The commissioner shall seek the necessary federal approval to implement this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2012, or upon federal approval, whichever is later.

Why enact a law for CP

- Established a criteria for eligibility to take the formal training course; and require formal approval by the State of Minnesota's college and University credentialing system.
- Established a separate certification for CP distinct from other providers so that their level of training and expertise is understood. This assures a degree of consistency so that there is limited confusion when the term "Community Paramedic" is used.
- Without legally establishing CPs as a distinct entity, payment for services would have been nearly impossible.
- Assure that CPs operate under a physicians license, allowing broad discretion in training and procedures they may perform.

Enacting a law-Continued

- Assure that the states regulatory authority would have the power to discipline,sanction, limit or remove a CP certification.
- To provide at least a measure of legal liability protection for virtually everyone involved in the CP operation from the training institution, to the oversight of physician to the CP.
- In some jurisdictions with tightly crafted regulations, performing services not specifically covered in law, may be considered practicing medicine without a license.
- Last, being in permanent state law legitimizes Community Paramedic as a legally recognized, clearly identifiable member of the health care delivery system.

Questions and Contact Info

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