DRAFT 2018

Economic Affairs Interim Committee
Pat Murdo, Committee Staff

FINAL REPORT TO THE 66TH MONTANA LEGISLATURE

EXAMINING MEDICAL SCOPES OF PRACTICE TO BETTER SERVE COMMUNITIES & VETERANS:

FINAL SJR 32 REPORT

Economic Affairs Interim Committee Members

Before the close of each legislative session, the House and Senate leadership appoint lawmakers to interim committees. The members of the Economic Affairs Interim Committee, like most other interim committees, serve one 20-month term. Members who are reelected to the Legislature, subject to overall term limits and if appointed, may serve again on an interim committee. This information is included in order to comply with 2-15-155, MCA.

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SUMMARY

This report is a summary of the work of the Economic Affairs Interim Committee specific to the Economic Affairs Interim Committee's 2017-2018 study under Senate Joint Resolution 32, as outlined in the Economic Affairs Interim Committee's 2017-18 work plan and SJR 32 (2017). Members received additional information and public testimony on the subject, and this report is an effort to highlight key information and the processes followed by the Economic Affairs Interim Committee in reaching its conclusions. To review additional information, including audio minutes, and exhibits, visit the Economic Affairs Interim Committee website: https://leg.mt.gov/eaic.

RECOMMENDATIONS

The Economic Affairs Interim Committee chose to devote most of its time to the SJR 27 study of the Montana State Fund and workers' compensation in Montana. For the SJR 32 study and the SJR 20 study assigned to the committee by the Legislative Council, the Economic Affairs Interim Committee devoted certain meetings to presentations and to reviews of the final reports. The final recommendations for this SJR 32 study include recognition:

- that Montana's limited population of emergency care providers is best used to provide broad emergency care, without distinguishing the population to be served;
- that learning more about the needs of veterans is good for every health care provider, and that existing knowledge bases may be helpful as references whenever health care providers develop continuing education or supplemental courses for emergency care providers in areas that involve veterans; and
- that veterans be encouraged to seek eligibility for Veterans Administration benefits as soon as possible after returning from deployment, even if health risks are not readily apparent.

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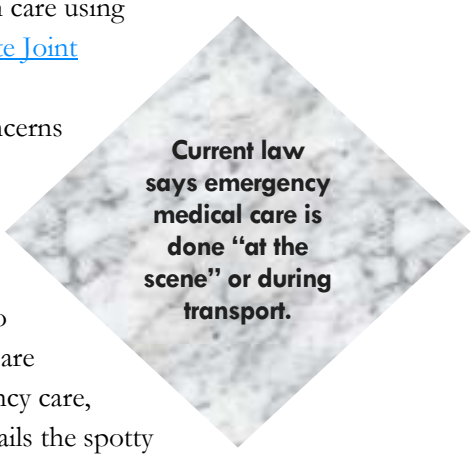
EXAMINING MEDICAL SCOPES OF PRACTICE TO BETTER SERVE COMMUNITIES & VETERANS

OVERVIEW

The Senate Joint Resolution 32 study combined aspects of Senate Bill 104, which sought changes in the way the emergency care system operates in Montana, and House Bill 612, which sought changes in how emergency care systems address the needs of veterans and members of the active military. Part of the intent of the study was to examine in more depth how those now licensed to provide emergency care might meet nonemergency needs in a community as well as the health care needs of veterans and active military. Based on the interests of the Economic Affairs Interim Committee, the presentations focused more on veterans' issues than on community paramedicine, a shorthand description of community-integrated health care using emergency care providers for nonemergencies. Separately, under Senate Joint Resolution 21, the Local Government Interim Committee looked at community paramedicine as a way to address workload and billing concerns of some emergency care providers, including firefighters.



This final report provides information presented to the Economic Affairs Interim Committee plus related information that was part of the SJR 21 study on community paramedicine, particularly as related to SB 104. Recognizing that many emergency care providers in Montana are volunteers who take time out OF their paying jobs to provide emergency care, the studies of both SJR 32 and SJR 21 resulted in information that details the spotty coverage for health care in general in rural Montana as well as concerns about payment for emergency or community paramedicine services.

BARRIERS TO NONEMERGENT COMMUNITY CARE

A key sticking point for emergency care providers being allowed to provide nonemergent community care to anyone, including veterans and active military, is in the statement of public policy behind licensure of emergency care providers. That statement (with relevant language emphasized in bold italics) says:

> **50-6-201. Legislative findings— duty of board.** (1) The legislature finds and declares that prompt and efficient ***emergency medical care of the sick and injured at the scene and during transport to a health care facility*** is an important ingredient necessary for reduction of the mortality and morbidity rate during the first critical minutes ***immediately after an accident or the onset of an emergent condition*** and that a program for emergency medical technicians is

required in order to provide the safest and most efficient delivery of emergency care.

(2) The board has a duty to ensure that emergency medical technicians provide proper treatment to patients in their care.

Senate Bill No. 104 in the 2017 session proposed changing that language to allow a "care system" for people who require emergency and community-based prehospital care. One concern voiced during the 2017 committee discussions of SB 104 was that volunteer emergency medical services might be called upon to handle nonemergency situations, which would mean that the volunteers were away from their paying job for something that was not an emergency. Not all volunteers wanted to be in that situation.

The Board of Medical Examiners, which oversees emergency care providers, supported SB 104 with proposed amendments from the Department of Labor and Industry that would have focused the bill primarily on allowing licensed emergency care providers, which includes emergency medical technicians, to incorporate some forms of community-based health care. A statement from the Department of Labor and Industry, to which the Board of Medical Examiners is administratively attached, explained in an April 2018 email to the Economic Affairs Interim Committee:

> Removing the barrier of only providing emergency services would increase health care access and lower costs. Emergency care providers have the knowledge and skill that can be utilized in other health care settings. The Board, with appropriate input from medical professionals, could modify the licensing for nonemergency situations.

Study Plan Issues

The Economic Affairs Interim Committee received a work plan at its first meeting in June 2017 and adopted the plan at its second meeting in September 2017. The work plan for SJR 32 (see the bill in Appendix 1) included the following tasks:

- Review current laws related to training, licensure, and scope of practice for emergency care providers (ECPs). The ECP coordinator for the Department of Labor and Industry provided an outline of the current scope of practice for four levels of emergency care providers at the Nov. 7, 2017, Economic Affairs Interim Committee meeting (see Appendix 2). The information covered types of skills for which the ECPs must be trained and referenced for licensing by the Board of Medical Examiners.

Montana licenses four levels of emergency care providers:

- **Emergency responders**
- **Emergency medical technicians**
- **Advanced EMTs**
- **Paramedics**

- Study the role that emergency care providers could have in the overall health care system, particularly in providing community-based, nonemergency health care as a means of preventing the need for emergency care. The committee did not specifically hear from those who have expanded their approaches, but the Local Government Interim Committee, which studied emergency medical services under SJR 21, received a variety of information, including a report on emergency care providers and volunteer firefighter services that is somewhat related. Given the limited time that the Economic Affairs Interim Committee chose to spend on SJR 32, no presentations were planned on this subject. However, a summary of information presented to the Local Government Interim Committee is in this report.

- Examine the special health care needs of veterans and their families and whether a special endorsement in veteran emergency care is a solution to help address those needs. Professional care providers involved in veteran care presented information at the Nov. 7, 2017, meeting on this topic and voiced concerns about emergency providers bypassing existing assistance channels.

Study Plan Proposed Deliverables

- The study plan called for presentations by representatives of veterans, active military, emergency medical technicians, suicide prevention specialists, dispatchers, law enforcement, and others active in emergency care or nonemergency care and the training for both types of care. These presentations were made at the Nov. 7, 2017, EAIC meeting.
- Additionally, while the study plan suggested a variety of briefing papers, the committee's decision to limit time spent on presentations meant that few briefing papers were prepared for meetings. Instead, included in this final report are brief descriptions of topics that had been proposed for briefing papers:
    - The status of emergency care providers' training, scope of practice, and payment mechanisms in this state and options in other states related to community care. Appendix 2 describes the training and scope of practice information. The payment information is briefly described below, with an even briefer reference to other state experiences.
    - Veterans' health needs, existing services, and gaps in the system. This relates to one of the other aspects mentioned in the study plan, a review of options available for veteran mental and physical health care. An overview will be provided in this report.
    - Costs to patients with or without insurance for service using persons trained in various scopes of practice as compared with a person trained across disciplines. Actual cost of care is difficult to obtain, so "cost" to the patient recognizes that "cost" is a factor of charges minus deductibles or insurance, taking into account co-pays and deductibles. The type of provider may impact the charges. A brief subsection below looks at Medicare fee guidelines for people with different skill levels, but the information does not address a person trained across disciplines—someone whose training may be broad but not deep.

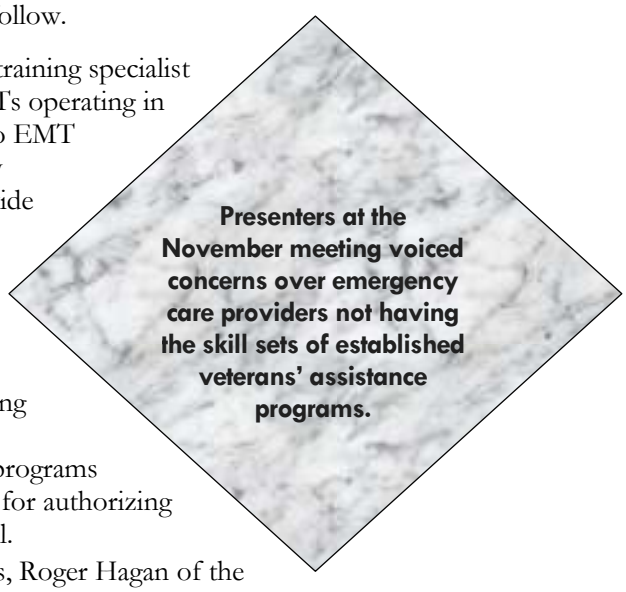
Presentations

For the study on emergency care providers and veterans, a six-person panel at the EAIC's Nov. 7, 2017, meeting reviewed various aspects of Senate Bill 104 and House Bill 612, neither of which was enacted.

EXAMINING MEDICAL SCOPES OF PRACTICE TO BETTER SERVE COMMUNITIES & VETERANS

Committee members received a staff overview of the Senate Joint Resolution 32 study, which the 2017 Legislature approved as a way of studying elements of both SB 104 and HB 612.

Among the November 2018 presenters were several related to veterans or military groups. Their main points were that a range of services already exists to help veterans. They suggested greater use of existing services and training opportunities. Summaries of the presentations follow.



- The state's emergency medical technician (EMT) training specialist provided an overview of the various types of EMTs operating in Montana. SB 104 had proposed several changes to EMT operations. One option was to revise the statutory references to allow emergency responders to provide nonemergent types of health care under specific conditions.
- A representative from the Board of Veterans Affairs, Joe Foster, pointed out concerns related to HB 612's recommendations for training EMTs who respond to veteran mental health crises, among other health services. Of particular concern was a disconnect, he said, between the various training programs already available and the limited criteria proposed for authorizing receipt of federal training funds under the G.I. Bill.
- A representative for auxiliary service organizations, Roger Hagan of the American Legion, voiced concerns that, by expanding emergency care options, a bill like HB 612 might distract veterans from accessing existing, appropriate services. He also provided written comments that emphasized the use of existing resources specific to veterans rather than mixing ongoing assistance concerns with emergency services.
- A representative of the National Guard noted that many Guard members are combat veterans and already have access to programs across the state, including Employee Assistance Programs that members are encouraged to access.
- An outpatient therapist at the Veterans Administration at Fort Harrison said that the outreach services sought by HB 612 already are provided by the VA and that veterans have the same access to care that other citizens do.
- The administrator at the Montana Law Enforcement Academy reviewed training done for dispatchers, including suicide training, and how dispatchers are trained to assess risks for immediate dangers. Materials provided by Chouteau County's 9-1-1 communications manager included an email containing suggestions for dispatchers and a copy of Chouteau County's protocols for dispatchers.

Concerns Related to 2017 Bills on Emergency Care and Veterans' Care

Although the demise of both SB 104 and HB 612 formed the background reasons for the SJR 32 study, the Economic Affairs Interim Committee spent most of its time looking at the HB 612 effort to expand emergency medical technician training to have a specific veteran component. The bill met concerns from various stakeholders who were unsure how Montana's limited supply of emergency care providers might be further put into service just for veterans.

SB 104

- Amendments proposed during discussions in the House Human Services Committee would have allowed emergency care providers to provide nonemergent care. The amendments were adopted but the bill was tabled in part because House Bill 612 with overlapping intent was moving forward. One committee member also voiced concern that volunteer emergency responders might not want to offer community paramedicine when they already were having trouble responding to emergency calls that took them away from regular work demands.
- One Human Services Committee member noted that the expansion of scope might result in fewer emergency care providers because of the greater number of duties for volunteers.

HB 612

- There was a concern that the training required under HB 612 for emergency care providers overlapped the training required for other personnel, who might have more specific training yet not be contacted in an emergency.
- The bill was considered unwarranted and unnecessary by some, because of the implication that veterans would be addressed with more attention than others, with particular concern that the emergency responder would need to know the amount of information included in the bill related to veterans' needs.
- There was a concern that two types of emergency responders would be required, with those able to serve veterans being trained in more fields (like nutrition) than typical emergency responders are trained. The additional requirements were considered a potential liability for encouraging (and signing up) volunteer responders.

Background Related to Community Medicine

In March 2017, the Local Government Interim Committee heard presentations from two care providers involved in using their emergency care components for community paramedicine pilot projects. Glacier County's project developed an integrated mobile health service that relied on a patient's health care provider referring the patient to the program. Once the patient was accepted into the program, the patient's health care provider worked with the "community paramedic" on such items as Foley catheter changes, basic wound care, chronic illness management, and patient education. A report on the grant outcomes is expected in late 2018.

Two pilot projects--one in Glacier County and one in Red Lodge --used a community paramedicine approach.

For both the Glacier program and a similar pilot project in Red Lodge, a major goal was to decrease the number of visits to the hospital's emergency department that may be prevented through timely follow-up care that may reduce potential complications. The Red Lodge program received a $450,000, 5-year grant from the Montana Community Foundation to coordinate the availability of community paramedicine. The Glacier program had funding from the Montana Healthcare Foundation and worked with the Kalispell Regional Medical Center to reduce hospital readmissions for program participants.

EXAMINING MEDICAL SCOPES OF PRACTICE TO BETTER SERVE COMMUNITIES & VETERANS

Background Related to Volunteer Emergency Services

The Department of Public Health and Human Services (DPHHS) had licensed 126 emergency medical services programs as of June 2018. These come under a variety of labels, ranging from fire departments that contain an emergency medical care component to quick-response units that do not transport patients but that provide medical care at accident scenes or the scene of emergency illnesses, such as heart attacks or strokes.

Montana licenses 126 emergency medical services programs – 70 of which are fully volunteer. Of the remaining, 23 pay all staff, and 33 are a mix of paid and volunteer.

While DPHHS licenses the emergency medical services, the Board of Medical Examiners licenses the emergency care providers, whether they be emergency medical technicians, paramedics, nurses, doctors, or physician assistants who may serve on ambulances. If nurses serve on ambulances, they are licensed by the Board of Nursing. All of the boards that license medical personnel are attached to the Department of Labor and Industry.

One of the initial components of SB 104 was to reorganize the licensing statutes for emergency care providers—the broad term for paramedics and various levels of emergency medical technicians—by putting those statutes under the professional and occupational licensing part of Montana law, Title 37. Currently, Montana laws put EMT licensing by the Board of Medical Examiners in Title 50, which is the home for emergency medical services laws. Distinguishing licensing of the services from licensing of the providers became less important as SB 104 traveled through the Legislature. Some advocates thought the bill's importance was in allowing emergency care providers to offer community medicine. The Department of Labor and Industry provided amendments to SB 104 that removed the reorganization but kept the community paramedicine concept in the bill. The Local Government Interim Committee asked for a bill that used SB 104 as a starting place and incorporated the amendments into what was proposed as LCVFF2, which became LC 127. The Local Government Interim Committee requested that bill in an attempt to expand the scope of practice and allow volunteer firefighters who also provide emergency medical services to handle nonemergent calls and bill accordingly.

The Economic Affairs Interim Committee chose not to make recommendations on the community paramedicine bill draft requested by the Local Government Interim Committee.

Currently, ambulance services, which may include volunteer firefighters, can bill only for transport or for emergency care, which is specified by their scope of practice. But they often get called out for nonemergent calls; these calls may be considered not medically necessary by the insurers, Medicare, or Medicaid, who then do not cover those bills considered not medically necessary. That means the volunteer services face unreimbursed costs unless the patient pays the bill. See Table 1 for an example of how one volunteer ambulance service in Lincoln gets reimbursed for services.

EXAMINING MEDICAL SCOPES OF PRACTICE TO BETTER SERVE COMMUNITIES & VETERANS

The Local Government Interim Committee indicated support for LC 126 as a way of helping volunteer firefighters offer—and bill for—community paramedicine. The Economic Affairs Interim Committee decided not to make recommendations regarding the bill draft requested by the Local Government Interim Committee. However, information made available to the Local Government Interim Committee for its SJR 21 study was also applicable for the SJR 32 study in terms of data describing what is available in rural and urban Montana for emergency services and health care in general. Appendix 3 shows which of Montana's 56 counties have hospitals and how many licensees there are for various general medical and emergency medical care plus the number of licensed ambulance or related emergency responder units. Among the health care providers listed by active license (which does not mean the licensee is necessarily available for medical care) are advanced practice registered nurses, medical doctors, and physician assistants plus each type of emergency care provider. Appendix 3 also shows whether a community is served by home health services, which in some cases offers the types of nonemergent care that are included in community paramedicine. One difference between the Appendix 3 information for the SJR 32 study and the information for the SJR 21 study is that the latter also listed whether a community's fire relief association receives money from the general fund for the Fire Department Relief Associations' disability and pension funds, authorized under Title 19, chapter 18, MCA.

Case Study of Billing by Lincoln Volunteer Ambulance Service	
Basic bill for quick response call, without transport	$300
Amount of bill paid for by insurance, if available	Usually $0
Basic life support for ambulance transport to hospital	$1,400
Advanced life support (includes intravenous line, oxygen)	$1,500
Advanced life support (includes the above + medications)	$1,600
Amount ambulance receives from Medicare/Medicaid on basic ambulance transport (Medicare pays shortest distance, even though shorter distance via Stemple Pass is partly on gravel and takes 25 minutes longer to reach Helena)	Approximately $500-$600
Percent of calls that are Medicare or Medicaid	About 75%
Amount of billing sent to collections as unpaid (multi-year)	$260,000
Costs for running ambulance service annually	~ $60,000
Of which: Costs for workers' compensation annually	~$14,000
Savings for ambulance replacement ($190,000)	$0
Personnel costs	volunteer
Average delay in bill payment: Medicare/Medicaid	~ 12 months
Veterans Administration	~ 2 to 3 months

Source: Aaron Birkholz, who handles operations for the volunteer ambulance. He says management takes about 30 "volunteer" hours a week. (He and his wife own a coffee shop.)

Payment for Emergency and Nonemergent Services

Emergency medical service providers may bill insurance for services, although not all insurance coverage includes ambulance services. There are two components to the payment decision:

- Does the insurance policy cover emergency services? Even though emergency services is considered one of the essential benefits that insurers are supposed to cover under policies that must comply with the Affordable Care Act, insurance policies not offered on the health insurance exchanges do not necessarily have to meet the ACA coverage criteria. Coverage terms are in flux, so whether insurance offered by employers is considered "creditable coverage," containing essential benefits, is a question.

- What percentage of coverage does an insurance policy provide if it covers emergency services? For example, not all insurers cover at least half the cost of air ambulances, which was one of the issues the 2015-2016 Economic Affairs Interim Committee studied and then sought to address by recommending what became SB 44 in the 2017 Legislature. That bill had the effect of encouraging air ambulance providers to work with insurers to avoid putting the patient into a balance billing situation.

Medicare and Medicaid

While Medicare and Medicaid pay a portion of ambulance services, they do not always pay the full cost; however, patients covered by these federal and federal-state programs, respectively, cannot be balance billed. In Montana, the federal-state Medicaid program paid 134 ambulance providers $5,487,888 in FY 2016 and 133 ambulance providers $9,276,436 in FY 2017 for emergency medical services. (The increase in 2017 reflected the full year of Medicaid expansion, according to the DPHHS Health Resources Division.)

Indirectly, Medicare has created incentives for community paramedicine or home health services (which have their own set of eligibility criteria) by penalizing hospitals and not paying them for readmissions within a certain number of days after a discharge. This has resulted in hospitals looking for ways (and service providers) to handle follow-up care for discharged patients and help them follow their discharge plan, including appropriate filling of medications and follow-up visits to physicians.

Veterans Administration

For veterans, payment depends on where the veteran accesses services as well as the veteran's eligibility status. A veteran may use any health care that other citizens use, but payment by the Veterans Administration depends on whether the veteran has met eligibility criteria for veterans' benefits. Based on information available from a U.S. Department of Veterans Affairs website, the earlier that a veteran seeks to establish eligibility, the better for addressing problems before they lead to a crisis.

One of the Veterans Administration websites states: "Combat Veterans who were discharged or released from active service on or after Jan. 28, 2003, are eligible to enroll in the VA health care system for five years from the date of their discharge or release, regardless of their eligibility claim status."

Average wait times for VA appointments in Montana ranged in late July 2018 from 4 days at the Lewistown VA Clinic to 148 days at the Hamilton VA Clinic. Veterans may request same-day service, but a person familiar with the high veteran suicide rates in Montana said that veterans would benefit from getting an eligibility determination as soon as their deployment ends, whether they feel in need of medical care or

not. (For more information about the VA health care system, see https://explore.va.gov/health-care and https://www.accesstopwt.va.gov/Main/FindFacilities?LocationText=MT&ApptType=12&PatientType=1&SortOrder=1&Radius=50&UserLatitude=-1&UserLongitude=-1&SameDayServiceView=false# .)

Differentiated Fee Structures (or Not)

In terms of payments based on skill levels—one of the suggested deliverables for the SJR 32 study—trying to determine payments for emergency care providers as contrasted with payments for physicians, advanced practice registered nurses, or physician assistants was too much of a stretch for this study. The information is not available in easily comparable fashion because of various factors, like whether the care is provided in a facility or outside a facility or whether payments are bundled or under separate contract. Many insurers and others making payments follow the lead of Medicare, which does differentiate based on skill levels, particularly as to physicians compared with advanced practice registered nurses compared with physician assistants. But changes are occurring in regulations, making relevant comparisons difficult. One 2016 Medicare document indicated that nurse practitioners and physician assistants routinely received about 85% of the physician fee schedule. More recent information indicated a 90% basis. No information could be found specifically differentiating these levels of care with emergency care providers. The federally qualified health center in Helena noted that Medicare and Medicaid paid the Prospective Payment System rate regardless of the type of provider while private insurance differentiated payment rates by provider type.

Other States' Activities on Community Care

Back in 2010, the National Association of State EMS Officials had a Joint Committee on Rural Emergency Care. Their December report called community paramedicine "one of the most progressive and historically-based evolutions available to community-based healthcare and to the Emergency Medical Services arena." (See "Beyond 911: State and Community Strategies for Expanding the Primary Care Role of First Responders," National Conference of State Legislatures (NCSL) website, http://www.ncsl.org/research/health/expanding-the-primary-care-role-of-first-responder.aspx#Intro .) The report referenced information gathered by the Rand Corporation and others indicating that frequent emergency room visits could be reduced through the use of some form of community care that provides either preventive and educational assistance that helps to avoid a first emergency room visit or follow-up care to avoid repeat visits.

NCSL also described actions in two states that made legislative changes to allow community paramedicine:

- Minnesota, which in 2011 formally recognized community paramedics as a provider type and set out educational and training requirements and in 2012 authorized medical assistance reimbursement for community paramedicine services for specified high-risk patient types; and

- Maine, which in 2012 removed regulatory barriers and set up 12 pilot programs.

The NCSL report also noted the work of Fort Worth, Texas, in creating a Community Health Program that succeeded in reducing the volume of 9-1-1 calls, with cost savings from reduced emergency room charges and transports helping to pay for home visits and related program aspects. One of the program directors said the $500,000 cost of the program had saved more than twice that amount in emergency room costs.

Veterans' Physical and Mental Health Needs

Concerns about access to health care for veterans was one of the main drivers behind HB 612. However, the bill's approach of using emergency care providers, especially in a state where lightly populated areas are dominated by volunteer emergency care providers, appeared problematic to some legislators considering the legislation during the 2017 session. One intent behind HB 612 was to address the difficulties faced by veterans seeking physical or mental health care.

The Department of Veterans' Affairs has a hospital at Fort Harrison in Helena that provides a range of services, including surgery but not inpatient crisis-stage mental health care. Emergency psychiatric care is referred to the behavioral health unit at St. Peter's Hospital in Helena or to the Sheridan, Wyo., Veterans Affairs Health Care System. As one person familiar with the services at Fort Harrison said, getting quick local access was considered most appropriate for veterans in mental health crisis. Fort Harrison does provide inpatient care for post-traumatic stress disorder (PTSD) or substance use disorders as well as what is called humanitarian crisis care, which means basically that some evaluation is done and referrals scheduled for the appropriate care. Billing, however, may not be to veterans' benefits but to another insurance source.

In addition to the hospital at Fort Harrison, veterans can go to any clinic in 15 Montana communities, all of which have the use of telehealth services: Anaconda, Billings, Bozeman, Cut Bank, Glasgow, Glendive, Great Falls, Hamilton, Havre, Kalispell, Lewistown, Miles City, Missoula, and Plentywood. Montana VA provides same-day access for those needing referral for care. Scheduled care, however, as mentioned earlier, may have wait times that could interfere with prompt treatment, so having established eligibility is key.

Montana-Specific Crisis Attention Related to Veterans

A Crisis Intercept Mapping Team is examining crisis responses for veterans in Lewis and Clark County. The team is comprised of various community members in Helena, including hospital officials, crisis intervention trainers, Veterans Administration personnel, National Guard representatives, and a representative of the Governor's Office. The Crisis Intercept Mapping Team has on its agendas a study of the activities in Denver and Texas that use social workers in combination with 9-1-1 dispatch centers and emergency responders to allow immediate assessments of persons in crisis. The Helena-oriented project is funded by a federal Substance Abuse and Mental Health Services grant.

Another project funded by a federal Substance Abuse and Mental Health Services grant is called the Mayor's Challenge, which allowed Billings and Helena to team up as "one" of seven cities that receive technical assistance to prevent suicide, learn about innovative strategies and best practices, and then propose outcomes that will be measured in various time frames over the 2018 calendar year.

Other local information for emergency responders and training regarding suicide prevention, in particular, is available from the following websites:

- Gatekeeper Training: http://www.sprc.org/search/gatekeeper%20training
- Veterans Administration: https://www.montana.va.gov/services/Mental_Health.asp
  https://www.accesstocare.va.gov/
- Suicide Prevention Training: https://dphhs.mt.gov/suicideprevention/suicideresources

Appendix 1

SENATE JOINT RESOLUTION 32

INTRODUCED BY A. OLSZEWSKI

BY REQUEST OF THE SENATE PUBLIC HEALTH, WELFARE, AND SAFETY STANDING COMMITTEE

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING THAT AN APPROPRIATE LEGISLATIVE INTERIM COMMITTEE STUDY EMERGENCY CARE PROVIDER TRAINING AND SCOPE OF PRACTICE AND THEIR ROLE IN THE HEALTH CARE SYSTEM AND REPORT ITS FINDINGS AND ANY RECOMMENDATIONS TO THE 66TH LEGISLATURE.

WHEREAS, Senate Bill No. 104 (2017) proposed allowing licensed emergency care providers to provide care within their current scope of practice but in nonemergency settings as part of a community integrated health care system; and

WHEREAS, House Bill No. 612 (2017) proposed allowing emergency care providers who receive additional training to earn an endorsement as a community veteran emergency care provider to provide community-based care to veterans and their families; and

WHEREAS, the Legislature acknowledges the merit of each bill and the need for an indepth examination of how licensed emergency care providers may be able to meet critical health care needs in nonemergency settings and in providing needed health care services to veterans and their families, including suicide prevention.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Legislative Council be requested to designate an appropriate interim committee, pursuant to section 5-5-217, MCA, to examine:

(1) the current statutory structure of laws governing emergency medical care, the training, licensure, and scope of practice of emergency care providers, and how those statutes may need to be updated;

(2) the role emergency care providers play in the overall health care system and whether and how that role could be better integrated into providing community-based health care to prevent medical emergencies requiring hospitalization; and

(3) the special health care needs of veterans and their families, including the need for suicide prevention, how a special additional endorsement as a community veteran emergency care provider would help meet those needs, and the scope of services allowed under such an endorsement.

BE IT FURTHER RESOLVED, that the study include input from interested stakeholders, including but not limited to the board of medical examiners, the department of labor and industry, the department of public health and human services, the department of military affairs, the Montana medical association, the Montana hospital association, ambulance services, entities that provide education and training for emergency care providers, emergency care providers, veterans and their families, and the office of public instruction as the state approving authority for training that may be paid for using a veteran's educational benefits.

BE IT FURTHER RESOLVED, that all aspects of the study be concluded prior to September 15, 2018.

BE IT FURTHER RESOLVED, that the final results of the study, including any findings, conclusions, or recommendations of the appropriate interim committee, be reported to the 66th Legislature.

- END -

Appendix 2

Levels of Emergency Care Providers

There are four levels of emergency care providers licensed by the Board of Medical Examiners. Each level builds on the skills of the preceding level. Each license is for 2 years, and renewal requires additional continuing education. See the handout from the November 2017 meeting for the scope of practice, which is summarized here.

- Emergency medical responder

  Continuing education consists of an EMR refresher course.

  --Allowed to insert devices into airway (oropharynx); use positive pressure ventilation devices; suction upper airway; provide supplemental oxygen therapy
  --Can use auto-injector for life-saving medications in hazardous materials situations
  --Can use automated external defibrillator
  --In traumas, can stabilize suspected cervical spine injuries and extremity fractures as well as control bleeding and undertake emergency moves
  --Additional endorsements available to administer Naloxone or operate a pulse oximeter

- Emergency medical technician

  Continuing education for EMTs is 48 hours on EMT course topics plus an EMT refresher course.

  --Additional ability to insert airway devices into nasopharynx (as well as oropharynx); use a KING airway
  --Can use additional positive pressure ventilation devices
  --Can use pneumatic anti-shock garment for fractures
  --Can assist patient in taking own prescriptions and, with medical oversight, can provide oral glucose, aspirin, epinephrine, nitroglycerin, naloxone, albuterol, Narcan, auto-injector morphine, flu vaccine, Benadryl (among others)
  --Can initiate intravenous lines and maintain peripheral IV/IO sites for "clear" fluids

- Advanced emergency medical technician

  Continuing education for AEMTs is 36 hours on EMT course topics plus an AEMT refresher course.

  --Allowed to insert airways not intended to be placed in the trachea and to do tracheobrachial suctioning of already intubated patient
  --Allowed to do assessments
  --Allowed to establish and maintain peripheral intravenous access, intraosseous access in a child
  --Allowed to administer nonmedicated intravenous fluid therapy
  --Allowed to administer sublingual nitroglycerin in suspected ischemic attacks and to administer

subcutaneous or intramuscular epinephrine in cases of anaphylaxis
--Allowed to administer glucagon and intravenous D50 in cases of hypoglcycemia
--Allowed to administer inhaled beta agonists in cases of breathing difficulty
--Allowed to administer a narcotic antagonist in case of suspected overdose
--Allowed to administer nitrous oxide for pain relief
--Endorsements allow initiating first-line cardiac medication for resuscitation and carrying and administering Benadryl, flu vaccine, auto-injected morphine, and decadron, Solu-Cortef, or Solu-Medrol.

- Paramedic

Continuing education for paramedics is 24 hours on EMT course topics plus a paramedic refresher course.

--Allowed to perform endotracheal intubation
--Allowed to perform percutaneous cricothyrotomy
--Allowed to decompress the pleural space and perform gastric decompression
--Allowed to insert an intraosseous cannula
--Allowed to administer enteral and parenteral medications (already prescribed)
--Allowed to access indwelling catheters, implanted IV ports to administer fluids and medications
--Allowed to administer medications by IV infusion
--Allowed to maintain blood/blood product infusion
--Allowed to perform cardioversion, manual defibrillation, and transcutaneous pacing
--Endorsement allowed for critical care if under oversight of a physician

Appendix 3

Emergency Care Providers, Ambulance Services, Hospitals, and Home Health Service by County
(see separate document)

EXAMINING MEDICAL SCOPES OF PRACTICE TO BETTER SERVE COMMUNITIES & VETERANS

Medical Service Providers, Ambulance or Fire-Related Responders (June 2018), and Home Health

County	Hospital w/ ER	MD/DO 6/15/2018	APRN 6/15/2018	Phys.Ass't 6/15/2018	E Med Responders as of 6/15/2018	EMTs in county (on ambulance) 6/15/2018	EMT-adv 6/15/2018	Paramedic 6/15/2018	Ambulance/ Related units on file with DPHHS
Beaverhead	Barrett Hosp. CAH-Dillon	20	8	7	1	13 (10)	12 (9)		Dillon-AV (commmunity vol)
			(2 RNs)			1+1 Dell (4)	1 (3)		Lima-RFD - volunteer
			(1 RN)			1	4 (5)		Polaris-FV
						2	3		Wisdom-AV (community vo
		1	(1 RN)		1	4	1		Wise River-FV
Big Horn	PHS Indian Hosp-Crow Agency	1					0	1	
	Big Horn County CAH-Hardin	11	5	3	1	7 (9)	0(2)	7(22)	Hardin-AP
Blaine		2	4		2	6(6)	11(9)	1(2)	Chinook-AV
			(2RNs)			1 Zurich (6)	(2)		Fort Belknap-Tribal Vol.
		1	2(1)			6 + 1 Hays(3)	4(6)		Harlem-MA
					1 Hogeland+1 Turner	4	2		Hogeland-AV
Broadwater	Health Cntr-Townsend	2		3	1 Toston + 1 Townsend	13+2Toston+1Winston(12)	2(3)	3(2)	Townsend-AV
Carbon		1	1(1 RN)		1	3+1 Edgar (10)	1	1(1)	Bridger - FV (community vo
						5			
		1				13Jol.+1Boyd (14)	0 (1)	0 (3)	Joliet -AV (community vol)
	Red Lodge CAH	14	(3 RNs)	2	1	23RL+1Belfry+ 7Roberts(24)	10 (9)	6 (4)	Red Lodge-FM
Carter		0	1	2	1Boyes	10+1Alzada, 1Hammond (11)	1 (1)		Ekalaka-AV
Cascade		4	2	1		4 (3)	7 (6)	1(1)	Belt-AV community vol
		4	1			4	4	1	
	Great Falls -Benefis Great Falls Hospital	209	99+2	30	1 Fort Shaw	96 +5Vaughn+ 2 Fort Shaw+2SunRiver+1Ulm (19)	24 (7)	60 (29)	Great Falls-FP+Fort Shaw (a
				3		10 + 3 Loma (10)	(1)		Big Sandy-AV (comm'ty vol
Chouteau	CAH-Fort Benton	1	3+2Flowerree +1Carter		1	10 + 3 Carter+1 Sq.Butte(12)	5(5)		Fort Benton-AV comm'ty vo
						5 + 4 Highwood (6)	(2)	1	Geraldine-AV comm'ty vol
Custer	CAH-Miles City	20		6		13 + 1 Ismay (10)	6 (3)	4 (3)	Miles City F-Rescue-FP
Daniels	Health Cntr-Scobey	1		1	1	3+1Flaxville, 2Richland (3)	6 (6)		Scobey-AV (gov't vol)
Dawson	Glendive Medical Cntr	10	4	6		8 (8)	8 (8)		Glendive-AV (gov't vol)
						4 (5)	(3)		Richey-AV (gov't vol)
Deer Lodge	Community Hosp. of Anac. CAH	16	10	2	3	6 (2)	15 (10)	1	Anaconda-FP
Fallon	CAH-Baker	5	1	3		7 (6)	4 (3)		Baker-AM (gov't mixed)
		1	1			1CoffeeCrk (11)	9 (2)		Denton-AV (comm'ty vol)
Fergus					2	7 (6)	3 (3)		Grass Range-AV(comm'ty v
	CAH-Lewistown	22	(2 RNs)			22+3 Hilger+1Moore+4Roy(12)	15 (10)	5 (9)	Lewistown-AP
							2		
						(6)	2 (2)		Roy-AV (comm'ty vol)
						3 (6)			Winifred-AV (comm'ty vol)
Flathead		14	9			20 (12)	7 (9)	2 (13)	Bigfork-MF
		13	8 +1Hungry Horse		6	17+3Coram, 3W.Glacier, 2HungryHorse (4)	6 (2)	14 (6)	Columbia Falls-AP
									Creston-FV (nontransport)
			(1 RN)			(16)	(7)	1 (12)	Evergreen-F-M
	KRMC-Kalispell	277	70	44	3	68 (2 Smith Valley, 8 W. Valley)	31 (23 Kalispell, 2 Smith Valley, 2W.Valley)	44 (8 Kalispell, 4 Smith Valley)	S.Kalispell-FV Kalisp-Smith Valley FV/AV Kalispell-FP/AP
									West Valley -FV
		6	1	4		12 + 2 Somers (11)	5 (5)	3 (5)	Lakeside-QRU-V (comm'ty v
		2	1 (+1Kila)		2 Kila + 2 Marion	15 Marion + 1 Kila (15)	4 (2)		Marion FDist-M
			2	1		1	Olney FV/AV		Olney FV-AP
	CAH-Whitefish	73		13		25 (3 Whitefish, 12 Big Mntn)	7 (1 Wh'fish, 6 Big Mntn)	17 (17 Whitefish, 2 Big Mntn)	WhitefishCity-FP WhitefishBigMntn-FP
		11	13 (1 RN)	5	1	37 (13)	9 (3)	14 (10)	Belgrade-FP
	CAH -Big Sky	16	1	1		68 (15 AP)	2 (11FM+3AP)	11 (9FM+2AP)	Big Sky-FM + AP (private)
	Bozeman Health Deac. Hosp.	274	86	68	14	345 (17)	23 (8)	38 (29)	Bozeman-AP
Gallatin		3		1	1	25	6	2	
		1		1	5 Three Forks +1 Willow Creek	11+ 1Willow Creek (9)	6 (6)	1 (1)	Three Forks-AV Three Forks-FSA-V
					1	7 +15 Gallatin Gtwy (3)	3 (3)	4 (3)	W.Yellowstone-FDistM
Garfield	CAH-Jordan			2		6 +1Cohagen (6)	6 (12)		Jordan-AV (comm'ty vol)
Glacier			5 (E.Glacier)		2	3Babb+1E.Glacier (3)	2 (4)	1 (3)	Babb/StMary-MA
	CAH-Blackfeet-Browning	2	1 (1 RN)		1	7 (6)	11 (5)	2	Browning-TribeAP
	CAH-Cut Bank	4	6			9 (8)	3 (7)	6 (13)	Cut Bank-AM (comm'ty vol)
Golden Valley					1	5			
		1				1 (4)	2 (1)		Ryegate A-QRU-V (c'mty vo
Granite			1			1 + 1 Hall (3)	6 (7)	(1)	Drummond-AV (comm'ty vo
	Med Cntr-Phillipsburg	2		1	2	8 (2)	5 (6)		Philipsburg-AV (comm'ty vo
Hill	Northern MT Hosp-Havre	28	12	5	1 Gildford + 3 Havre	11+4 K-G,3Hingham (9)	12 (8)	2	Havre-FP
			1+ Box Elder			2 Box Elder (2)	(5)		Rocky Boy's Box Elder AP
			(1 RN)		2	2	(11)		Rudyard-AV (gov't vol)
Jefferson			1	1		4 (3)	8 (4)	1	Boulder-AV (gov't vol)
			20+1	2	2	10Clancy, 2JeffersonCity	8	5	
						(21)	(7)		Montana City-AP (private)
			(5 RNs)	1	3	13 (17)	5 (13)	3 (1)	Whitehall-AV (comm'ty vol)
Judith Basin			1			5 + 1 Moccasin	3		
						2Geyser 2Raynesford	2	1	Raynesford/Geyser QRU-V
						6 (6)	2 (11)	1 (1)	Stanford-AV (comm'ty vol)
			2 (Big Arm)	1		13 (12)	3 (3)		Arlee FV
Lake	CAH-Polson	25	11+	6	2+4Dayton	17 + 3 Dayton (14)	4 (5)	8 (21)	Polson/Ronan/St. Ignatius
	CAH-Ronan			5		8	2	3	(ambulance staff listed unc
						3 + 2Charlo	0	2	Pablo).
						2 (3)	4 (4)		Augusta AV (comm'ty vol)
			6	3	5	25	5	2	
Lewis and Clark	St. Peter's-Helena		63	39	13	83+3 CanyonCrk + 1 Ft Harrison, 1 Marysville (8)	38 (10)	25 (29)	Helena-AP
	Fort Harrison VA		4						
		1		0	7	3 (10)	5 (5)		Lincoln-AV (comm'ty vol)
Liberty	Liberty County Hosp. CAH	1	1	3		14 +1 Joplin (16)	0 (2)		Chester-QRU-V (gov't vol)
Lincoln		8	2	3		16 + 2 Fortine (10)	6 (5)	1	Eureka-AV (comm'ty vol)
	CAH-Libby	18		7	5	14 + 3 Rexford (9)	14 (8)	3 (1)	Libby-FM/AM (comm'ty vol
					1	16 (15)	2 (4)	2 (3)	Trey-AM (comm'ty vol)
Madison	CAH-Ennis	2	3		2	6 +2Cameron+4McAllister(9)	8(8)	1(2)	Ennis-AV comm'ty vol
		1-Pony			1				
						2Alder+4Cardwell+1Norris			
	CAH-Sheridan	3	(1 RN)	3		9 (10)	(2)	3 (4)	Sheridan-AM
		1		1		7	7	1	
		1							
McCone	CAH-Circle			2		16+2Brockway+1Vida (11)	6 (5)		Circle-AV (comm'ty vol)
Meagher	Med Cntr-Wh.Sulphur Springs					9+ 1Martinsdale, 1Ringling (19)		1	Whitsulphursprings-AV (comm'ty vol)
Mineral	CAH-Superior	1	2+	3	1 St. Regis	9+ 2Alberton+2StRegis (10)	7 (9)		Superior-AV (comm'ty vol)
				1		9 Condon (8)			Condon/Swan QRU-V (cmty vol
				0		17 + 2De Borgia, 3Huson (23)	7 (8)	2 (6)	Frenchtown-FM
Missoula	Community			74	6	25S+6 Bonner, 10 Clinton, 2Greenough, 1 Milltown, 1Potomac (32)	46 (3)	60 (27)	Missoula-AP
	St. Patrick								
		5			1	16 (12)	1(1)	2(3)	Seeley Lake-FM
Musselshell	CAH-Roundup	1	(1 RN)	4	1Melstone + 4Roundup	15+3 Melstone+2 Musselshell (8)	1(3)	1(1)	Roundup-AM (gov't)
Park		0	1		1 Cooke City	8+2CookeCty (3)	3 + 1Pray	18(7)	Emigrant-FV
	CAH-Livingston					14 (12)			Gardiner-FV
		33		7	1 Livingston + 2 Wilsall	30 + 4Wilsall+3ClydePrk(11)	5(1)	(14)	Livingston-FM
Petroleum						7(10)	5(8)	(1)	Winnett-AV
Phillips	CAH-Malta	1	(6 RNs)	1	1 Loring	15 + 1 Dodson (14)	2(2)		Malta-AV (comm'ty vol)
				1		1	2		
Pondera	Pondera Med Cntr-Conrad	4	2(+1Brady)	2	1	7(10)	3(5)	3(8)	Conrad-AV (comm'ty vol)
		1	2		1 Heart Butte+1Valier	3+1 Heart Butte	2	1	
Powder River	Med Cntr-Broadus		1 (1 RN)			6(8)	(1)		Broadus-AV
Powell		1			2	1+ 1Elliston, 1 Helmville (5)	3(3)		Avon VF-QRU (comm'ty vol
Prairie		5	3+1Garrison	3		5(9)	4(4)	(1)	Deer Lodge-AV (comm'ty vo
		0		1		4(3)	4(2)	(1)	Terry-AV (comm'ty vol)
			1	1	1 (Conner)	6	6	3	
Ravalli			8	4	1	10 + 17 Lolo	7		Florence F-QRU-V
	Marcus Daly Mem Hosp. CAH	45	11	5		21+1P+3Pinesdale (13)	7(19)	9(28)	Hamilton-AP
					1 Corvallis+1Stevi	27+ 8Corvallis (13)	11+4Corvallis(3)	9	Stevensville-FV
			7+1Corvallis	2		6(5)	(6)	(4)	Victor FV
Richland		3				2	1	2	
	Health Cntr-Sidney	12	1+3Crane	3		12 4 Lambert+3Savage(21)	12(21)		Sidney-AV
	CAH-Culbertson		(1 RN)	2		5 +5Bainville (9)	4(9)	(1)	Culbertson-AV
Roosevelt							2		
	CAH-Poplar		(3 RN)		1	8 WolfPoint+ 5 Poplar+ 2 Brockton (28)	1		Poplar/WolfPoint-AP
	CAH-Wolf Point		1 Brockton	1			4 (9)	1(1)	
Rosebud			1	3	14		6(3)	2(1)	Colstrip-AV (comm'ty vol)
	Rosebud Health Cntr-Forsyth		1	2	3	14(13)	3(2)	3(2)	Forsyth-AM
			1+1Ashland			4+4 Ashland (5)	3(4)	(3)	Lame Deer-AM Tribal
					1	1	1		Rosebud-AM
Sanders						1(2)	4(3)	(1)	Hot Springs-AV (comm'ty v
					3 Dixon + 1 Noxon	3+2 Dixon+ 3Heron+3TroutCrk (8)	3(2)	(1)	Noxon-AV (comm'ty vol)
			1 Dixon	3		11 +1 Paradise(10)	4(4)		Plains-AV (comm'ty vol)
	CAH-Thompson Falls	1	(1 RN)	4	1	7(6)	3(2)	(1)	Thompson Falls-AV(cmty v
						2 + 2 Dagmar	0		
Sheridan	CAH-Plentywood	1	(1 RN)		1	7+ 1 Outlook(14)	4(7)	(1)	Plentywood -AM
		0				1	0		
Silver Bow	St. James-Butte	73	33(2 RNs)	16	4	64 + 1 Melrose (11)	23(7)	7	Butte-AP
Stillwater		0	(1 RN)	2	3	7 + 2Fishtail+2Nye(11)	2(2)		Absarokee-AV (comm'ty vo
	Stillwater Cmnty Hosp. CAH	3	1	5		15 + 1 Reedpoint(17)	2(6)	5(11)	Columbus-FM
						9(7)		1	Park City-AV (comm'ty vol)
Sweet Grass	Pioneer Medical Center	3	2 (1 RN)	2	1	16 + 1 McLeod (15)	7 (10)	4(4)	Big Timber-AV
Teton	Benefis Teton Med Cntr-Choteau	2	3	2	4 Choteau +1 Pendroy	8+ 2Bynum+7Pendroy(46)	5(17)	1(2)	Choteau-AM (gov't)
		2	2	1	2 Power	6 + 7 Power	0		
						8	7		
Toole						1 Oilmont	1		
	Shelby Med Cntr	4				8(5)	6(9)		Shelby-AM
				1		3	1		
Treasure		1	2			7 +1Sanders (8)	0(2)		Hysham-AM
Valley	CAH-Glasgow	10	5+1Hinsdale	4	2	13+1 Hinsdale (23)	8(7)		Glasgow-AM
						1+5 Frazer, 1Larslan, 1Lustre			
						6(9)			Opheim-AV (comm'ty vol)
	CAH-Harlowton		4			10(17)			Harlowton-AV (gov't)
Wheatland						6			
Wibaux						8(6)	3(4)		Wibaux-AV (comm'ty vol)
Yellowstone	Billings Clinic	622	121 (1 RN)	141	3	1 Action + 221 Billings+ 4 Broadview (30)	30 (2)	96(38)	Billings-AP
	St. Vincent's-Billings								
		10	8	1	1	18 (10)	8(6)	1(2)	Laurel-AV (comm'ty vol)
						(5)	(1)	(7)	Lockwood FM
		1	1 Huntley	1		1 Worden+ 1Huntley+9Shepherd (4)	3(5)	3	Worden-AV (comm'ty vol)

NOTE 1: Information on licensing from mid-June 2018 from Department of Labor and Industry. Information on ambulance types and staffing of ambulances (in parentheses) from Department of Public Hea and Human Services.

NOTE 2: Abbreviations: FV = Fire Dept. Vols.; AV = Ambulance Vol.; AP= Paid Ambulance; FP = Paid [illegible] on ambulance, fire unit; FSA= service area; Fdist=Fire District. Ambulance units may be governmental non-fire, hospital-based, [illegible]

NOTE 3: Towns in bold in the column listing Fire Relief Associations indicate town of the third class.

EXAMINING MEDICAL SCOPES OF PRACTICE TO BETTER SERVE COMMUNITIES & VETERANS