OCTOBER 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 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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*Rep. Nate McConnell of Missoula started the interim as a member of the Economic Affairs Interim Committee but was named as a senator early in 2018 and his "representative" spot was then assigned to Rep. Lynch.

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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). SJR 32 addressed the use of emergency care responders for community care and, specifically, as an option to help veterans. Members received additional information and public testimony on the SJR 32 subjects. 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/committees/interim/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 on unemployment, 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 the following:

- Recognize that Montana's limited population of emergency care providers is best used to provide broad emergency care, without distinguishing the population to be served, but that certain communities may benefit from using emergency care providers in concert with other professional health care providers to enhance access to health care.
- Propose that prior to any rulemaking on continuing education or supplemental courses for emergency care providers in areas that involve veterans, the Board of Medical Examiners notify, and consider input from, the Veterans Affairs Administration and state veterans' organization and agencies. This recommendation can stand alone regardless of the outcome of the proposed bill draft LCVFF2.

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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 to the committee focused more on veterans' issues than on community paramedicine. Separately, the Local Government Interim Committee looked at the role of community paramedicine that might be addressed by emergency medical services and firefighters under Senate Joint Resolution 21.

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 that information related to SB 104. Recognizing that many emergency care providers in Montana are volunteers who take time of out their paying jobs to provide emergency care, the studies of both SJR 32 and SJR 21 resulted in information in this report that details the spotty coverage for health care in general as well as concerns about payment for those 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:

- Review current laws related to training, licensure, and scope of practice for emergency care providers (ECP). The ECP coordinator for the Department of Labor and Industry provided an outline[1] 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 A. The information covered types of skills for which the ECPs must be trained and referenced the licensing by the Board of Medical Examiners.

- 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 report[2] on emergency care providers and volunteer firefighter

[1] See "Current Scope of Practice for Emergency Care Providers, Nov. 7, 2017, EAIC meeting presentation at: https://leg.mt.gov/content/Committees/Interim/2017-2018/Economic-Affairs/Meetings/Nov-2017/EMT-scope-of-practice11-2017.pdf.
[2] See "SJR 21 Study of Emergency Medical and Volunteer Firefighter Services Systems: Mid-Interim Review" at https://leg.mt.gov/content/Committees/Interim/2017-2018/Local-Government/Meetings/Mar-2018/FIRE-SJR21Review.pdf.

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. Presenters at the Nov. 7, 2017, meeting addressed 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, the study plan suggested briefing papers on:
    - 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. The training and scope of practice information is in Appendix A. The payment information and other state comparable experiences are to be provided in this report.
    - 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.

Presentations

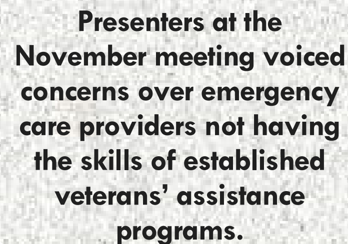
For the study on emergency care providers and veterans, a six-person panel at the EAIC's Nov. 7, 2017, meeting reviewed various aspects of Senate Bill 104 and House Bill 612, neither of which was enacted. Committee members received a staff overview[3] of the Senate Joint Resolution 32 study, which the 2017 Legislature approved as a

[3] See "SJR 32 Overview: Perspectives on Emergency Care Concerns," prepared for the Nov. 7, 2017, EAIC meeting. https://leg.mt.gov/content/Committees/Interim/2017-2018/Economic-Affairs/Meetings/Nov-2017/SJR32-overview.pdf.

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 exist to help veterans. They suggested greater use of existing services and training opportunities. Summaries of the presentations follow.

- The state's emergency medical technician training specialist provided an overview[4] 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 pointed out concerns related to HB 612's recommendations for training EMTs that respond to veteran mental health crises, among other health services. Of particular concern was a disconnect, Joe Foster 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[5] 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



[4] See "Current Scope of Practice for Emergency Care Providers," op. cit.
[5] See Roger A. Hagan, "Testimony before the Economic Affairs Interim Committee," 11/07/2017, at: https://leg.mt.gov/content/Committees/Interim/2017-2018/Economic-Affairs/Committee-Topics/SJR32/auxiliary-presentation-hagan112017.pdf.

included an email[6] containing suggestions for dispatchers and a copy of Chouteau County's protocols[7] for dispatchers.

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

SB 104

- Amendments proposed during discussions in the House Human Services Committee would have allowed, not required, emergency care providers to provide. The amendments were adopted but the bill was tabled in part because House Bill 612 with overlapping intent was moving forward.
- 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 by emergency care providers overlapped the required training for other personnel, who had more training and might not be contacted.
- 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 responder.

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 medicine pilot projects. Glacier County has developed an integrated mobile health service that relies on a patient's health care provider referring them to the program. Once the patient is accepted into the program, the patient's health care provider works with the "community paramedic" on such items as foley catheter changes, basic wound care, chronic illness management, and patient education.

For both the Glacier program and a similar pilot project in Red Lodge a major goal is to decrease the number of visits to the hospital's emergency department that may be prevented through timely followup care that may reduce potential complications. The Red Lodge program received a $450,000, five-year grant from the Montana

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[6] See Nov. 6, 2017, email from Kimberly Burdick with the Association of Public-Safety Communications Officials at https://leg.mt.gov/content/Committees/Interim/2017-2018/Economic-Affairs/Meetings/Nov-2017/sjr32-apco-guidance-re-veterans.pdf.

[7] See Chouteau County Communications Center Call Guidelines, provided at the EAIC meeting Nov. 7, 2017, at https://leg.mt.gov/content/Committees/Interim/2017-2018/Economic-Affairs/Meetings/Nov-2017/sjr32dipatcher-suicide-call-protocol-sample.pdf.

Community Foundation to coordinate the availability of community paramedicine. The Glacier program worked with the Kalispell Regional Medical Center to reduce program participant readmissions and was able to share in the cost-savings achieved.

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, like heart-attacks. 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.

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.

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, instead of having the EMTs licensing references under Title 50 with the emergency medical services program. Separating the services from 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 proposed LCVFF2 (see Appendix 2) put those amendments into SB 104 as a starting place.

The reason that LCVFF2 has been put forward under the SJR 32 study is that the SJR 32 study incorporated both SB 104 and HB 612 concerns. As one indication that the subject of community paramedicine had broad support, the topic became part of the SJR 21 study assigned to the Local Government Interim Committee. SJR 21 is a study of quality emergency medical and volunteer firefighter services in Montana, intended to address concerns about personnel shortages and challenges facing rural communities in need of fire protection and medical care.

A table prepared jointly for the SJR 21 study and for the SJR 32 study is available in Appendix 3 and shows Montana counties that have hospitals as well as lists by county of various health care providers, including licensees for emergency medical care, advanced practice registered nurses, medical doctors, and physician assistants. The table also shows ambulance or related units licensed by DPHHS, whether a community is served by home health services, and whether a community's fire relief association receives funding from 5% of the fire insurance premium tax.

Although both SB 104 and HB 612 were part of the background for SJR 32, 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.

Payment for Emergency and Nonemergent Services

Emergency medical service providers may bill insurance for services, although not all insurance coverage includes ambulance services. Although 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, not all insurance policies meet the same coverage criteria. For example, not all insurance covers 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.

While Medicare and Medicaid pay a portion of ambulance services, they do not always pay the full cost, but patients covered by these federal and federal/state programs, respectively, cannot be balance billed..

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 the payment depends on the veterans' own insurance coverage if not considered eligible for veterans' benefits.

Indirectly, Medicare has created incentives for community paramedicine 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 provide followup to discharged patients to help them follow their discharge plan, including appropriate filling of medications and followup visits to physicians.

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[8] accessed June 19, 2018.) The report referenced information gathered by the Rand Corporation and others that frequent emergency room visits could be reduced through the use of some form of community medicine that either provides preventive and educational care prior that helps to avoid a first emergency room visit or followup care to avoid repeat visits.

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

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

[8] See "Beyond 911: State and Community Strategies for Expanding the Primary Care Role of First Responders," at www.ncsl.org.

- 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.

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 must rely on 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 perceived—or actual—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 crisis-stage mental health care. Emergency psychiatric care is referred to the behavioral health unit at St. Peter's Hospital in Helena. 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. But 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 telehealth capability: Anaconda, Billings, Bozeman, Cut Bank, Glasgow, Glendive, Great Falls, Hamilton, Havre, Kalispell, Lewistown, Miles City, Missoula, and Plentywood.

Montana-Specific Crisis Information for Veterans

A Crisis Intercept Mapping Team, comprised of various community members in Helena ranging from hospital officials, crisis intervention trainers, Veterans' Administration personnel, National Guard representatives and a representative of the Governor's Office, are working on mobile crisis responses for veterans. Among examples that may be studied are 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.

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 I

SENATE JOINT RESOLUTION NO. 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.

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

Proposed LCVFF2, requested by the Local Government Interim Committee for review

A Bill for an Act entitled: "An Act allowing emergency care providers to be involved in community-integrated health care services under the regulation of the board of medical examiners; updating terminology; extending rulemaking authority; allowing department of public health and human services to offer guidance to ambulance services and nontransporting medical units regarding options for community-integrated health care; amending sections 2-15-1731, 7-33-4510, 7-34-102, 37-3-102, 37-3-203, 37-3-303, 37-20-303, 37-27-104, 39-71-118, 45-5-214, 46-4-114, 50-6-101, 50-6-103, 50-6-105, 50-6-201, 50-6-202, 50-6-203, 50-6-206, 50-6-301, 50-6-302, 50-6-323, 50-6-506, 50-16-701, 61-2-502, 61-2-503, and 61-2-504, MCA; and providing an effective date."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 2-15-1731 , MCA, is amended to read:

"2-15-1731. Board of medical examiners. (1) There is a Montana state board of medical examiners.

(2) The board consists of 13 members appointed by the governor with the consent of the senate. Appointments made when the legislature is not in session may be confirmed at the next session.

(3) The members are:

(a) five members having the degree of doctor of medicine, including one member with experience in emergency medicine;

(b) one member having the degree of doctor of osteopathy;

(c) one member who is a licensed podiatrist;

(d) one member who is a licensed nutritionist;

(e) one member who is a licensed physician assistant;

(f) one member who is a licensed acupuncturist;

(g) one member who is a volunteer emergency ~~medical technician~~ care provider, as defined in ~~50-6-202~~ 37-3-102; and

(h) two members of the general public who are not medical practitioners.

(4) (a) The members having the degree of doctor of medicine may not be from the same county.

(b) The volunteer emergency ~~medical technician~~ care provider must have a demonstrated interest in and knowledge of state and national issues involving emergency medical service and community integrated health care.

(c) Each member must be a citizen of the United States.

(d) Each member, except for public members, must have been licensed and must have practiced medicine, acupuncture, emergency medical care, or dietetics-nutrition in this state for at least 5 years and must have been a resident of this state for at least 5 years.

(5) Members shall serve staggered 4-year terms. A term begins on September 1 of each year of appointment. A member may be removed by the governor for neglect of duty, incompetence, or unprofessional or dishonorable conduct.

(6) The board is allocated to the department for administrative purposes only as prescribed in 2-15-121."

Section 2. Section 7-33-4510 , MCA, is amended to read:

"7-33-4510. Workers' compensation for volunteer firefighters -- notification if coverage not provided -- definitions. (1) An employer may provide workers' compensation coverage as provided in Title 39, chapter 71, to any volunteer firefighter who is listed on a roster of service.

(2) An employer may purchase workers' compensation coverage from any entity authorized to provide workers' compensation coverage under plan No. 1, 2, or 3 as provided in Title 39, chapter 71.

(3) If an employer provides workers' compensation coverage as provided in this section, the employer may, upon payment of the filing fee provided for in 7-4-2631(1)(a), file a roster of service with the clerk and recorder in the county in which the employer is located and update the roster of service monthly if necessary to report changes in the number of volunteers on the roster of service. The clerk and recorder shall file the original and replace it with updates whenever necessary. The employer shall maintain the roster of service with the effective date of membership for each volunteer firefighter.

(4) If an employer does not provide workers' compensation coverage, the employer shall annually notify the employer's volunteer firefighters that coverage is not provided.

(5) For the purposes of this section, the following definitions apply:

(a) (i) "Employer" means the governing body of a fire agency organized under Title 7, chapter 33, including a rural fire district, a fire service area, a volunteer fire department, a volunteer fire company, or a volunteer rural fire control crew.

(ii) The term does not mean a governing body of a city of the first class or second class, including a city to which 7-33-4109 applies, that provides workers' compensation coverage to employees as defined in 39-71-118.

(b) "Roster of service" means the list of volunteer firefighters who have filled out a membership card prior to performing services as a volunteer firefighter.

(c) (i) "Volunteer firefighter" means a volunteer who is on the employer's roster of service. A volunteer firefighter ~~includes~~ may include a volunteer emergency ~~medical technician~~ care provider as defined in ~~50-6-202~~ 37-3-102 who is on the roster of service. A volunteer firefighter is not required to be an active member as defined in 19-17-102.

(ii) The term does not mean an individual who is not listed on a roster of service or a member of a volunteer fire department provided for in 7-33-4109."

Section 3. Section 7-34-102 , MCA, is amended to read:

"7-34-102. Ambulance service mill levy permitted. Subject to 15-10-420 and in addition to all other levies authorized by law, each county, city, or town may levy an annual tax on the taxable value of all taxable property within the county, city, or town to defray the costs incurred in providing

ambulance service. These costs may include workers' compensation coverage for emergency ~~medical technicians~~ care providers on volunteer duty with the ambulance service or members of a paid or volunteer nontransporting medical unit defined in 50-6-302."

Section 4. Section 37-3-102 , MCA, is amended to read:

"37-3-102. Definitions. Unless the context requires otherwise, in this chapter, the following definitions apply:

(1) "ACGME" means the accreditation council for graduate medical education.

(2) "AOA" means the American osteopathic association.

(3) "Approved internship" means an internship training program of at least 1 year in a program that either is approved for intern training by the AOA or conforms to the standards for intern training established by the ACGME or successors. However, the board may, upon investigation, approve any other internship.

(4) "Approved medical school" means a school that either is accredited by the AOA or conforms to the education standards established by the LCME or the world health organization or successors for medical schools that meet standards established by the board by rule.

(5) "Approved residency" means a residency training program conforming to the standards for residency training established by the ACGME or successors or approved for residency training by the AOA.

(6) "Board" means the Montana state board of medical examiners provided for in 2-15-1731.

(7) "Community-integrated health care" means the provision of out-of-hospital medical services that an emergency care provider may provide as determined by board rule.

~~(7)~~(8) "Department" means the department of labor and industry provided for in Title 2, chapter 15, part 17.

~~(8)~~(9) "Emergency care provider" or "ECP" means ~~an emergency care provider~~ a person licensed by the board, including but not limited to an emergency medical responder, an emergency medical technician, an advanced emergency medical technician, or a paramedic. An emergency care provider may have an enhanced endorsement to provide community-integrated health care.

~~(9)~~(10) "LCME" means the liaison committee on medical education.

~~(10)~~(11) "Medical assistant" means an unlicensed allied health care worker who functions under the supervision of a physician, physician assistant, or podiatrist in a physician's or podiatrist's office and who performs administrative and clinical tasks.

~~(11)~~(12) "Physician" means a person who holds a degree as a doctor of medicine or doctor of osteopathy and who has a valid license to practice medicine or osteopathic medicine in this state.

~~(12)~~(13) "Practice of medicine" means the diagnosis, treatment, or correction of or the attempt to or the holding of oneself out as being able to diagnose, treat, or correct human conditions, ailments, diseases, injuries, or infirmities, whether physical or mental, by any means, methods, devices, or instrumentalities, including electronic and technological means such as telemedicine. If a person who does not possess a license to practice medicine in this state under this chapter and who is not exempt from the licensing requirements of this chapter performs acts constituting the practice of medicine, the person is practicing medicine in violation of this chapter.

~~(13)~~(14) (a) "Telemedicine" means the practice of medicine using interactive electronic communications, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine typically involves the application of secure videoconferencing or store-and-forward technology, as defined in 33-22-138.

(b) The term does not mean an audio-only telephone conversation, an e-mail or instant messaging conversation, or a message sent by facsimile transmission."

Section 5. Section 37-3-203 , MCA, is amended to read:

"37-3-203. Powers and duties -- rulemaking authority. (1) The board may:

(a) adopt rules necessary or proper to carry out the requirements in Title 37, chapter 3, parts 1 through 4, ~~as well as~~ and of chapters covering podiatry, acupuncture, physician assistants, nutritionists, and emergency care providers as set forth in Title 37, chapters 6, 13, 20, and 25, and 50-6-203, respectively. ~~The rules must be fair, impartial, and nondiscriminatory.~~ Any rules adopted for emergency care providers must address their role in community-integrated health care, their scope of practice, competency requirements, and educational requirements.

(b) hold hearings and take evidence in matters relating to the exercise and performance of the powers and duties vested in the board;

(c) aid the county attorneys of this state in the enforcement of parts 1 through 4 and 8 of this chapter as well as Title 37, chapters 6, 13, 20, and 25, and Title 50, chapter 6, regarding emergency care providers licensed by the board. The board also may assist the county attorneys of this state in the prosecution of persons, firms, associations, or corporations charged with violations of the provisions listed in this subsection (1)(c).

(d) review certifications of disability and determinations of eligibility for a permit to hunt from a vehicle as provided in 87-2-803(11); and

(e) fund additional staff, hired by the department, to administer the provisions of this chapter, by increasing license fees as necessary.

(2) (a) The board shall establish a medical assistance program to assist and rehabilitate licensees who are subject to the jurisdiction of the board and who are found to be physically or mentally impaired by habitual intemperance or the excessive use of addictive drugs, alcohol, or any other drug or substance or by mental illness or chronic physical illness.

(b) The board shall ensure that a licensee who is required or volunteers to participate in the medical assistance program as a condition of continued licensure or reinstatement of licensure must be allowed to enroll in a qualified medical assistance program within this state and may not require a licensee to enroll in a qualified treatment program outside the state unless the board finds that there is no qualified treatment program in this state.

(3) (a) The board shall report annually on the number and types of complaints it has received involving physician practices in providing written certification, as defined in 50-46-302, for the use of marijuana for a debilitating medical condition provided for in Title 50, chapter 46. The report must contain:

(i) the number of complaints received by the board pursuant to 37-1-308;

(ii) the number of complaints for which a reasonable cause determination was made pursuant to 37-1-307;

(iii) the general nature of the complaints;

(iv) the number of investigations conducted into physician practices in providing written certification; and

(v) the number of physicians disciplined by the board for their practices in providing written certification for the use of marijuana for a debilitating medical condition.

(b) Except as provided in subsection (3)(c), the report may not contain individual identifying information regarding the physicians about whom the board received complaints.

(c) For each physician against whom the board takes disciplinary action related to the physician's practices in providing written certification for the use of marijuana for a debilitating medical condition, the report must include:

(i) the name of the physician;

(ii) the general results of the investigation of the physician's practices; and

(iii) the disciplinary action taken against the physician.

(d) The board shall provide the report to the children, families, health, and human services interim committee by August 1 of each year and shall make a copy of the report available on the board's website.

(4) The board may enter into agreements with other states for the purposes of mutual recognition of licensing standards and licensing of physicians and ~~ECPs~~ emergency care providers from other states under the terms of a mutual recognition agreement."

Section 6. Section 37-3-303 , MCA, is amended to read:

"37-3-303. Practice authorized by physician's license. A physician's license authorizes the holder to perform one or more of the acts embraced in ~~37-3-102(12)~~ 37-3-102(13) in a manner consistent with the holder's training, skill, and experience."

Section 7. Section 37-20-303 , MCA, is amended to read:

"37-20-303. Exemptions from licensure requirement. (1) This chapter does not prohibit or require a license as a physician assistant for the rendering of medical or medically related services if the service rendered is within the applicable scope of practice for any of the following individuals:

(a) a physician assistant providing services in an emergency or catastrophe, as provided in 37-20-410;

(b) a federally employed physician assistant;

(c) a registered nurse, an advanced practice registered nurse, a licensed practical nurse, or a medication aide licensed or authorized pursuant to Title 37, chapter 8;

(d) a student physician assistant when practicing in a hospital or clinic in which the student is training;

(e) a physical therapist licensed pursuant to Title 37, chapter 11;

(f) a medical assistant, as provided in 37-3-104;

(g) an emergency ~~medical technician~~ care provider licensed pursuant to Title 50, chapter 6; or

(h) any other medical or paramedical practitioner, specialist, or medical assistant, technician, or aide when licensed or authorized pursuant to laws of this state.

(2) A licensee or other individual referred to in subsection (1) who is not a licensed physician assistant may not use the title "PA" or "PA-C" or any other word or abbreviation to indicate or induce others to believe that the individual is a physician assistant."

Section 8. Section 37-27-104 , MCA, is amended to read:
"37-27-104. Exemptions. This chapter does not limit or regulate the practice of a licensed physician, certified nurse-midwife, or licensed ~~basic or advanced emergency medical technician~~ emergency care provider. The practice of direct-entry midwifery does not constitute the practice of medicine, certified nurse-midwifery, or emergency medical care to the extent that a direct-entry midwife advises, attends, or assists a woman during pregnancy, labor, natural childbirth, or the postpartum period when the pregnancy is not a high-risk pregnancy."

Section 9. Section 39-71-118 , MCA, is amended to read:
"39-71-118. Employee, worker, volunteer, volunteer firefighter, and volunteer emergency ~~medical technician~~ care provider defined -- election of coverage. (1) As used in this chapter, the term "employee" or "worker" means:

(a) each person in this state, including a contractor other than an independent contractor, who is in the service of an employer, as defined by 39-71-117, under any appointment or contract of hire, expressed or implied, oral or written. The terms include aliens and minors, whether lawfully or unlawfully employed, and all of the elected and appointed paid public officers and officers and members of boards of directors of quasi-public or private corporations, except those officers identified in 39-71-401(2), while rendering actual service for the corporations for pay. Casual employees, as defined by 39-71-116, are included as employees if they are not otherwise covered by workers' compensation and if an employer has elected to be bound by the provisions of the compensation law for these casual employments, as provided in 39-71-401(2). Household or domestic employment is excluded.

(b) any juvenile who is performing work under authorization of a district court judge in a delinquency prevention or rehabilitation program;

(c) a person who is receiving on-the-job vocational rehabilitation training or other on-the-job training under a state or federal vocational training program, whether or not under an appointment or contract of hire with an employer, as defined in 39-71-117, and, except as provided in subsection (9), whether or not receiving payment from a third party. However, this subsection (1)(c) does not apply to students enrolled in vocational training programs, as outlined in this subsection, while they are on the premises of a public school or community college.

(d) an aircrew member or other person who is employed as a volunteer under 67-2-105;

(e) a person, other than a juvenile as described in subsection (1)(b), who is performing community service for a nonprofit organization or association or for a federal, state, or local government entity under a court order, or an order from a hearings officer as a result of a probation or parole violation, whether or not under appointment or contract of hire with an employer, as defined in 39-71-117, and whether or not receiving payment from a third party. For a person covered by the definition in this subsection (1)(e):

(i) compensation benefits must be limited to medical expenses pursuant to 39-71-704 and an impairment award pursuant to 39-71-703 that is based upon the minimum wage established under Title 39, chapter 3, part 4, for a full-time employee at the time of the injury; and

(ii) premiums must be paid by the employer, as defined in 39-71-117(3), and must be based upon the minimum wage established under Title 39, chapter 3, part 4, for the number of hours of community service required under the order from the court or hearings officer.

(f) an inmate working in a federally certified prison industries program authorized under 53-30-132;

(g) a volunteer firefighter as described in 7-33-4109 or a person who provides ambulance services under Title 7, chapter 34, part 1;

(h) a person placed at a public or private entity's worksite pursuant to 53-4-704. The person is considered an employee for workers' compensation purposes only. The department of public health and human services shall provide workers' compensation coverage for recipients of financial assistance, as defined in 53-4-201, or for participants in the food stamp program, as defined in 53-2-902, who are placed at public or private worksites through an endorsement to the department of public health and human services' workers' compensation policy naming the public or private worksite entities as named insureds under the policy. The endorsement may cover only the entity's public assistance participants and may be only for the duration of each participant's training while receiving financial assistance or while participating in the food stamp program under a written agreement between the department of public health and human services and each public or private entity. The department of public health and human services may not provide workers' compensation coverage for individuals who are covered for workers' compensation purposes by another state or federal employment training program. Premiums and benefits must be based upon the wage that a probationary employee is paid for work of a similar nature at the assigned worksite.

(i) subject to subsection (11), a member of a religious corporation, religious organization, or religious trust while performing services for the religious corporation, religious organization, or religious trust, as described in 39-71-117(1)(d).

(2) The terms defined in subsection (1) do not include a person who is:

(a) performing voluntary service at a recreational facility and who receives no compensation for those services other than meals, lodging, or the use of the recreational facilities;

(b) performing services as a volunteer, except for a person who is otherwise entitled to coverage under the laws of this state. As used in this subsection (2)(b), "volunteer" means a person who performs services on behalf of an employer, as defined in 39-71-117, but who does not receive wages as defined in 39-71-123.

(c) serving as a foster parent, licensed as a foster care provider in accordance with 52-2-621, and providing care without wage compensation to no more than six foster children in the provider's own residence. The person may receive reimbursement for providing room and board, obtaining training, respite care, leisure and recreational activities, and providing for other needs and activities arising in the provision of in-home foster care.

(d) performing temporary agricultural work for an employer if the person performing the work is otherwise exempt from the requirement to obtain workers' compensation coverage under 39-71-401(2)(r) with respect to a company that primarily performs agricultural work at a fixed business location or under 39-71-401(2)(d) and is not required to obtain an independent contractor's

exemption certificate under 39-71-417 because the person does not regularly perform agricultural work away from the person's own fixed business location. For the purposes of this subsection, the term "agricultural" has the meaning provided in 15-1-101(1)(a).

(3) With the approval of the insurer, an employer may elect to include as an employee under the provisions of this chapter a volunteer as defined in subsection (2)(b) or a volunteer firefighter as defined in 7-33-4510.

(4) (a) If the employer is a partnership, limited liability partnership, sole proprietor, or a member-managed limited liability company, the employer may elect to include as an employee within the provisions of this chapter any member of the partnership or limited liability partnership, the owner of the sole proprietorship, or any member of the limited liability company devoting full time to the partnership, limited liability partnership, proprietorship, or limited liability company business.

(b) In the event of an election, the employer shall serve upon the employer's insurer written notice naming the partners, sole proprietor, or members to be covered and stating the level of compensation coverage desired by electing the amount of wages to be reported, subject to the limitations in subsection (4)(d). A partner, sole proprietor, or member is not considered an employee within this chapter until notice has been given.

(c) A change in elected wages must be in writing and is effective at the start of the next quarter following notification.

(d) All weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (4)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $900 a month and not more than 1 1/2 times the state's average weekly wage.

(5) (a) If the employer is a quasi-public or a private corporation or a manager-managed limited liability company, the employer may elect to include as an employee within the provisions of this chapter any corporate officer or manager exempted under 39-71-401(2).

(b) In the event of an election, the employer shall serve upon the employer's insurer written notice naming the corporate officer or manager to be covered and stating the level of compensation coverage desired by electing the amount of wages to be reported, subject to the limitations in subsection (5)(d). A corporate officer or manager is not considered an employee within this chapter until notice has been given.

(c) A change in elected wages must be in writing and is effective at the start of the next quarter following notification.

(d) For the purposes of an election under this subsection (5), all weekly compensation benefits must be based on the amount of elected wages, subject to the minimum and maximum limitations of this subsection (5)(d). For premium ratemaking and for the determination of the weekly wage for weekly compensation benefits, the electing employer may elect an amount of not less than $200 a week and not more than 1 1/2 times the state's average weekly wage.

(6) Except as provided in Title 39, chapter 8, an employee or worker in this state whose services are furnished by a person, association, contractor, firm, limited liability company, limited liability partnership, or corporation, other than a temporary service contractor, to an employer, as

defined in 39-71-117, is presumed to be under the control and employment of the employer. This presumption may be rebutted as provided in 39-71-117(3).

(7) A student currently enrolled in an elementary, secondary, or postsecondary educational institution who is participating in work-based learning activities and who is paid wages by the educational institution or business partner is the employee of the entity that pays the student's wages for all purposes under this chapter. A student who is not paid wages by the business partner or the educational institution is a volunteer and is subject to the provisions of this chapter.

(8) For purposes of this section, an "employee or worker in this state" means:

(a) a resident of Montana who is employed by an employer and whose employment duties are primarily carried out or controlled within this state;

(b) a nonresident of Montana whose principal employment duties are conducted within this state on a regular basis for an employer;

(c) a nonresident employee of an employer from another state engaged in the construction industry, as defined in 39-71-116, within this state; or

(d) a nonresident of Montana who does not meet the requirements of subsection (8)(b) and whose employer elects coverage with an insurer that allows an election for an employer whose:

(i) nonresident employees are hired in Montana;

(ii) nonresident employees' wages are paid in Montana;

(iii) nonresident employees are supervised in Montana; and

(iv) business records are maintained in Montana.

(9) An insurer may require coverage for all nonresident employees of a Montana employer who do not meet the requirements of subsection (8)(b) or (8)(d) as a condition of approving the election under subsection (8)(d).

(10) (a) An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county may elect to include as an employee within the provisions of this chapter a volunteer emergency ~~medical technician~~ care provider who serves public safety through the ambulance service not otherwise covered by subsection (1)(g) or the paid or volunteer nontransporting medical unit. The ambulance service or nontransporting medical unit may purchase workers' compensation coverage from any entity authorized to provide workers' compensation coverage under plan No. 1, 2, or 3 as provided in this chapter.

(b) If there is an election under subsection (10)(a), the employer shall report payroll for all volunteer emergency ~~medical technicians~~ care providers for premium and weekly benefit purposes based on the number of volunteer hours of each emergency ~~medical technician~~ care provider, but no more than 60 hours, times the state's average weekly wage divided by 40 hours.

(c) An ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, may make a separate election to provide benefits as described in this subsection (10) to a member who is either a self-employed sole proprietor or partner who has elected not to be covered under this chapter, but who is covered as a volunteer emergency ~~medical technician~~ care provider pursuant to subsection (10)(a). When injured in the course and scope of employment as a volunteer emergency ~~medical technician~~ care provider, a member may instead of the benefits described in subsection (10)(b) be eligible for benefits at an assumed wage of the minimum wage established under Title 39, chapter 3, part 4, for 2,080 hours a

year. If the separate election is made as provided in this subsection (10), payroll information for those self-employed sole proprietors or partners must be reported and premiums must be assessed on the assumed weekly wage.

(d) A volunteer emergency ~~medical technician~~ care provider who receives workers' compensation coverage under this section may not receive disability benefits under Title 19, chapter 17, if the individual is also eligible as a volunteer firefighter.

(e) An ambulance service not otherwise covered by subsection (1)(g) or a nontransporting medical unit, as defined in 50-6-302, that does not elect to purchase workers' compensation coverage for its volunteer emergency ~~medical technicians~~ care providers under the provisions of this section shall annually notify its volunteer emergency ~~medical technicians~~ care providers that coverage is not provided.

(f) (i) The term "volunteer emergency ~~medical technician~~ care provider" means a person who ~~has received a certificate issued~~ is licensed by the board of medical examiners as provided in Title 50, chapter 6, part 2, and who serves the public through an ambulance service not otherwise covered by subsection (1)(g) or a paid or volunteer nontransporting medical unit, as defined in 50-6-302, in service to a town, city, or county.

(ii) The term does not include a volunteer emergency ~~medical technician~~ care provider who serves an employer as defined in 7-33-4510.

(g) The term "volunteer hours" means the time spent by a volunteer emergency ~~medical technician~~ care provider in the service of an employer or as a volunteer for a town, city, or county, including but not limited to training time, response time, and time spent at the employer's premises.

(11) The definition of "employee" or "worker" in subsection (1)(i) is limited to implementing the administrative purposes of this chapter and may not be interpreted or construed to create an employment relationship in any other context."

Section 10. Section 45-5-214 , MCA, is amended to read:

"45-5-214. Assault with bodily fluid. (1) A person commits the offense of assault with a bodily fluid if the person purposely causes one of the person's bodily fluids to make physical contact with:

(a) a law enforcement officer, a staff person of a correctional or detention facility, or a health care provider, as defined in 50-4-504, including a health care provider performing emergency services, while the health care provider is acting in the course and scope of the health care provider's profession and occupation:

(i) during or after an arrest for a criminal offense;

(ii) while the person is incarcerated in or being transported to or from a state prison, a county, city, or regional jail or detention facility, or a health care facility; or

(iii) if the person is a minor, while the youth is detained in or being transported to or from a county, city, or regional jail or detention facility or a youth detention facility, secure detention facility, regional detention facility, short-term detention center, state youth correctional facility, health care facility, or shelter care facility; or

(b) an emergency responder.

(2) A person convicted of the offense of assault with a bodily fluid shall be fined an amount not to exceed $1,000 or incarcerated in a county jail or a state prison for a term not to exceed 1 year, or both.

(3) The youth court has jurisdiction of any violation of this section by a minor.

(4) As used in this section, the following definitions apply:

(a) "Bodily fluid" means any bodily secretion, including but not limited to feces, urine, blood, and saliva.

(b) "Emergency responder" means a licensed medical services provider, law enforcement officer, firefighter, volunteer firefighter or officer of a nonprofit volunteer fire company, emergency ~~medical technician~~ care provider, emergency nurse, ambulance operator, provider of civil defense services, or any other person who in good faith renders emergency care or assistance at a crime scene or the scene of an emergency or accident."

Section 11. Section 46-4-114 , MCA, is amended to read:

"46-4-114. Reporting fetal deaths. A licensed nurse, a midwife, a physician assistant, an emergency ~~medical technician~~ care provider, a birthing assistant, or any other person who assists in the delivery that occurs outside a licensed medical facility of a fetus that is believed or declared to be dead shall report the death by the earliest means available to the coroner of the county in which the death occurred."

Section 12. Section 50-6-101 , MCA, is amended to read:

"50-6-101. Legislative purpose. (1) The public welfare requires the providing of assistance and encouragement for the development of ~~a~~ comprehensive emergency medical services ~~program~~ and community-integrated health care for Montanans who each year are dying and suffering permanent disabilities needlessly because of inadequate ~~emergency~~ medical services. The repeated loss of persons who die unnecessarily because necessary life-support personnel and equipment are not available to victims of accidents and sudden illness is a tragedy that can and must be eliminated.

(2) Community-integrated health care is necessary to improve the health of Montana citizens, prevent illness and injury, reduce the incidence of emergency calls and hospital emergency department visits made for the purpose of obtaining nonemergency, nonurgent medical care or services, and to provide community outreach, health education, and referral services within communities.

(3) The development of an emergency medical services program and community-integrated health care is in the interest of the social well-being and health and safety of the state and all its people who require emergency and community-integrated medical care."

Section 13. Section 50-6-103 , MCA, is amended to read:

"50-6-103. Powers of department. (1) The department of public health and human services is authorized to confer and cooperate with any other persons, organizations, and governmental agencies that have an interest in the emergency medical services ~~problems and needs~~ program and community-integrated health care.

(2) The department is authorized to accept, receive, expend, and administer any funds that are now available or that may be donated, granted, or appropriated to the department.

(3) The department may, after consultation with the trauma care committee, the Montana committee on trauma of the American college of surgeons, the Montana hospital association, and the Montana medical association, adopt rules necessary to implement part 4 of this chapter.

(4) The department shall continually assess and, as needed, revise the functions and components that it regulates to improve the quality of emergency medical services and to ensure that the emergency medical services program adapts to the changing community-integrated health care needs of the citizens of Montana.

(5) The department shall collaborate with other components of the health care system to fully integrate the emergency medical services program into the overall health care system.

(6) As part of the collaboration under subsection (5), the department shall provide guidance to ambulance services and nontransporting medical units regarding their options to engage in community-integrated health care beyond offering emergency medical services."

Section 14. Section 50-6-105 , MCA, is amended to read:

"50-6-105. Emergency medical care standards -- review process. (1) The board of medical examiners shall establish patient care standards for:

(a) prehospital and interfacility emergency medical treatment and transportation; and

(b) community-integrated health care.

(2) (a) Complaints involving prehospital care, interfacility care, community-integrated health care, or the operation of an emergency medical service, as defined in 50-6-302, must be filed with the board and reviewed by a screening panel pursuant to 37-1-307.

(b) If a complaint is initially filed with the department of public health and human services, the department shall refer the complaint to the board for review by a screening panel.

(3) (a) When a complaint involves the operation or condition of an emergency medical service, the screening panel shall refer the complaint to the department for investigation as provided in 50-6-323.

(b) When a complaint involves patient care provided by an emergency ~~medical technician~~ care provider, the screening panel shall:

(i) refer the complaint to the board for investigation as provided in 37-1-308 and 50-6-203; and

(ii) forward to the department the complaint and the results of the screening panel's initial review as soon as the review is completed.

(c) When a complaint involves a combination of patient care and emergency medical service matters, the screening panel shall refer the complaint to both the department and the board for matters that fall within the jurisdiction of each entity.

(4) For a complaint involving patient care, the board shall:

(a) immediately share with the department any information indicating:

(i) a potential violation of department rules; or

(ii) that the existing policies or practices of an emergency medical service may be jeopardizing patient care; and

(b) notify the department when:

(i) a sanction is imposed upon an emergency ~~medical technician~~ care provider; or

(ii) the complaint is resolved.

(5) For a complaint involving an emergency medical service, the department shall:
(a) immediately share with the board any information indicating:
(i) a potential violation of board rules; or
(ii) that the practices of an emergency ~~medical technician~~ care provider may be jeopardizing patient care; and
(b) notify the board when:
(i) a sanction is imposed upon an emergency medical service; or
(ii) the complaint is resolved."
{*Internal References to 50-6-105:*

Section 15. Section 50-6-201 , MCA, is amended to read:
"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~~ care providers is required in order to provide the safest and most efficient delivery of emergency and community-integrated health care.
(2) The legislature further finds that prompt and efficient emergency medical care of the sick and injured at the scene and during transport to a health care facility is important in reducing the mortality and morbidity rate during the first critical minutes immediately after an accident or the onset of an emergent condition.
(3) The legislature further finds that community-integrated health care can prevent illness and injury and can help fill gaps in the state's health care system, particularly in rural communities with limited health care services and providers.
~~(2)~~(4) The board has a duty to ensure that emergency ~~medical technicians~~ care providers are properly licensed and provide proper treatment to patients in their care."

Section 16. Section 50-6-202 , MCA, is amended to read:
"50-6-202. Definitions. As used in this part, the following definitions apply:
(1) "Board" means the Montana state board of medical examiners provided for in 2-15-1731.
(2) "Emergency ~~medical technician~~ care provider" means a person ~~who has been specially trained in emergency care in a training program approved by the board and certified by the board as having demonstrated a level of competence suitable to treat victims of injury or other emergent condition~~ licensed by the board, including but not limited to an emergency medical responder, an emergency medical technician, an advanced emergency medical technician, or a paramedic. An emergency care provider may have an enhanced endorsement to provide community-integrated health care.
(3) "Volunteer emergency ~~medical technician~~ care provider" means an individual who is licensed pursuant to this part and provides prehospital, interfacility, emergency medical, or community-integrated health care:
(a) on the days and at the times of the day chosen by the individual; and

(b) for an emergency medical service other than:

(i) a private ambulance company unless the care is provided without compensation and outside of the individual's regular work schedule; or

(ii) a private business or a public agency, as defined in 7-1-4121, that employs the individual on a regular basis with a regular, hourly wage to provide emergency medical or community-integrated health care as part of the individual's job duties."

Section 17. Section 50-6-203 , MCA, is amended to read:

"50-6-203. Rules. (1) The board, after consultation with the department of public health and human services and other appropriate departments, associations, and organizations, shall adopt rules of the board implementing this part, including but not limited to:

(a) training and licensure of emergency ~~medical technicians~~ care providers;

(b) the administration of drugs by emergency ~~medical technicians~~ care providers; and

(c) the handling of complaints involving patient care provided by emergency ~~medical technicians~~ care providers.

(2) The board may, by rule, establish various levels of emergency ~~medical technician~~ care provider licensure and shall specify for each level the training requirements, acts allowed, relicensure requirements, and any other requirements regarding the training, performance, or licensure of that level of emergency ~~medical technician~~ care provider that it considers necessary, subject to the provisions of 37-1-138."

Section 18. Section 50-6-206 , MCA, is amended to read:

"50-6-206. Consent. ~~No~~ An emergency ~~medical technician~~ care provider may not be subject to civil liability for failure to obtain consent in performing acts as authorized ~~herein~~ in this part to any individual regardless of age ~~where~~ when the patient is unable to give consent and there is no other person present legally authorized to consent, provided that ~~such~~ the acts are in good faith and without knowledge of facts negating consent."

Section 19. Section 50-6-301 , MCA, is amended to read:

"50-6-301. Findings. The legislature finds and declares that:

(1) the public welfare requires the establishment of minimum uniform standards for the operation of emergency medical services;

(2) the control, inspection, and regulation of persons providing emergency medical services or community-integrated health care is necessary to prevent or eliminate improper care that may endanger the health of the public; and

(3) the regulation of emergency medical ~~care~~ services is in the interest of the social well-being and the health and safety of the state and all its people."

Section 20. Section 50-6-302 , MCA, is amended to read:

"50-6-302. Definitions. As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Aircraft" has the meaning provided in 67-1-101. The term includes any fixed-wing airplane or helicopter.

(2) (a) "Ambulance" means a privately or publicly owned motor vehicle or aircraft that is maintained and used for the transportation of patients.

(b) The term does not include:

(i) a motor vehicle or aircraft owned by or operated under the direct control of the United States; or

(ii) air transportation services, such as charter or fixed-based operators, that are regulated by the federal aviation administration and that offer no special medical services or provide only transportation to patients or persons at the direction or under the supervision of an independent physician.

(3) "Board" means the Montana state board of medical examiners provided for in 2-15-1731.

(4) "Community-integrated health care" means the provision of out-of-hospital medical services that an emergency care provider may provide as determined by board rule.

~~(4)~~(5) "Department" means the department of public health and human services provided for in 2-15-2201.

~~(5)~~(6) "Emergency medical service" means a prehospital or interfacility emergency medical transportation or treatment service provided by an ambulance or nontransporting medical unit that is licensed by the department to provide prehospital or interfacility emergency medical transportation or treatment services.

~~(6)~~(7) "Nonemergency ambulance transport" means the use of an ambulance to transport a patient between health care facilities, as defined in 50-5-101, including federal facilities, when the patient's medical condition requires special transportation considerations, supervision, or handling but does not indicate a need for medical treatment during transit or for emergency medical treatment upon arrival at the receiving health care facility.

~~(7)~~(8) "Nontransporting medical unit" means an aggregate of persons who are organized to respond to a call for emergency medical service and to treat a patient until the arrival of an ambulance. Nontransporting medical units provide any one of varying types and levels of service defined by department rule but may not transport patients.

~~(8)~~(9) "Offline medical direction" means the function of a board-licensed physician or physician assistant in providing:

(a) medical oversight and supervision for an emergency medical service or an emergency ~~medical technician~~ care provider; and

(b) review of patient care techniques, emergency medical service procedures, and quality of care.

~~(9)~~(10) "Online medical direction" means the function of a board-licensed physician or physician assistant or the function of a designee of the physician or physician assistant in providing direction, advice, or orders to an emergency ~~medical technician~~ care provider for prehospital, ~~and~~ interfacility, emergency medical, or community-integrated health care as identified in a plan for offline medical direction.

~~(10)~~(11) (a) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless.

(b) ~~The~~ Unless otherwise defined by rule for community-integrated health care, the term does not include an individual who is nonambulatory and who needs transportation assistance solely because that individual is confined to a wheelchair as the individual's usual means of mobility.

~~(11)~~(12) "Person" means an individual, firm, partnership, association, corporation, company, group of individuals acting together for a common purpose, or organization of any kind, including a governmental agency other than the United States.

~~(12)~~(13) "Volunteer emergency ~~medical technician~~ care provider" means an individual who is licensed pursuant to Title 50, chapter 6, part 2, and provides prehospital, interfacility, emergency medical, or community integrated health care:

(a) on the days and at the times of the day chosen by the individual; and

(b) for an emergency medical service other than:

(i) a private ambulance company, unless the care is provided without compensation and outside of the individual's regular work schedule; or

(ii) a private business or a public agency, as defined in 7-1-4121, that employs the individual on a regular basis with a regular, hourly wage to provide emergency medical or community-integrated health care as part of the individual's job duties."

Section 21. Section 50-6-323 , MCA, is amended to read:

"50-6-323. Powers and duties of department. (1) The department has general authority to supervise and regulate emergency medical services in Montana.

(2) Upon referral by a screening panel pursuant to 50-6-105, the department shall review and may investigate complaints relating to the operation of any emergency medical service.

(3) In investigating a complaint, the department may review:

(a) the type and condition of equipment and procedures used by an emergency medical service to provide care at the scene ~~or~~ during prehospital or interfacility transportation, or in other out-of-hospital care settings;

(b) the condition of any vehicle or aircraft used as an ambulance;

(c) general performance by an emergency medical service; and

(d) the results of any investigation conducted by the board concerning patient care by an emergency ~~medical technician~~ care provider who was, at the time of the complaint, providing care through the emergency medical service that is the subject of a complaint under investigation by the department.

(4) Upon completion of an investigation as provided in subsection (3), the department shall take appropriate action, including sharing information regarding complaints with the board as provided in 50-6-105 and initiating any necessary legal proceedings as authorized under this part.

(5) In order to carry out the provisions of this part, the department shall prescribe and enforce rules for emergency medical services. Rules of the department may include but are not limited to the following:

(a) the classification and identification of specific types and levels of prehospital and interfacility medical transportation or treatment services;

(b) procedures for issuing, denying, renewing, and canceling licenses issued under this part;

(c) minimum licensing standards for each type and level of service, including requirements for personnel, offline medical direction, online medical direction, maintenance, equipment,

reporting, recordkeeping, sanitation, and minimum insurance coverage as determined appropriate by the department; and

(d) other requirements necessary and appropriate to ensure the quality, safety, and proper operation and administration of emergency medical services.

(6) A rule adopted pursuant to this section ~~is not effective until:~~

~~(a) a public hearing has been held for review of the rule; and~~

~~(b) notice of the public hearing and a copy of the proposed rules have been sent to all persons licensed under 50-6-306 to conduct or operate an emergency medical service. Notice must be sent at least 30 days prior to the date of the public hearing~~ must comply with Title 2, chapter 4."

Section 22. Section 50-6-506 , MCA, is amended to read:

"50-6-506. Exemptions. This part does not apply to the use of an AED by:

(1) a patient or the patient's caretaker if use of the AED is ordered by a physician; or

(2) a licensed health care professional, including an emergency ~~medical technician~~ care provider, whose scope of practice includes the use of an AED."

Section 23. Section 50-16-701 , MCA, is amended to read:

"50-16-701. Definitions. As used in this part, the following definitions apply:

(1) "Airborne infectious disease" means an infectious disease transmitted from person to person by an aerosol, including but not limited to infectious tuberculosis.

(2) "Department" means the department of public health and human services provided for in 2-15-2201.

(3) "Designated officer" means the emergency services organization's representative and the alternate whose names are on record with the department as the persons responsible for notifying an emergency services provider of exposure.

(4) "Emergency services organization" means a public or private organization that provides emergency services to the public.

(5) "Emergency services provider" means a person employed by or acting as a volunteer with an emergency services organization, including but not limited to a law enforcement officer, firefighter, emergency ~~medical technician, paramedic~~ care provider, corrections officer, or ambulance service attendant.

(6) "Exposure" means the subjecting of a person to a risk of transmission of an infectious disease through the commingling of the blood or bodily fluids of the person and a patient or in another manner as defined by department rule.

(7) "Health care facility" has the meaning provided in 50-5-101 and includes a public health center as defined in 7-34-2102.

(8) "Infectious disease" means human immunodeficiency virus infection, hepatitis B, hepatitis C, hepatitis D, communicable pulmonary tuberculosis, meningococcal meningitis, and any other disease capable of being transmitted through an exposure that has been designated by department rule.

(9) "Infectious disease control officer" means the person designated by the health care facility as the person who is responsible for notifying the emergency services provider's designated officer and the department of an infectious disease as provided for in this part and by rule.

(10) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless."

Section 24. Section 61-2-502 , MCA, is amended to read:

"61-2-502. Definitions. As used in this part, the following definitions apply:

(1) "Aircraft" has the meaning provided in 67-1-101. The term includes any fixed-wing airplane or helicopter.

(2) (a) "Ambulance" means a privately or publicly owned motor vehicle or aircraft that is maintained and used for the transportation of patients.

(b) The term does not include:

(i) a motor vehicle or aircraft owned by or operated under the direct control of the United States; or

(ii) air transportation services, such as charter or fixed-based operators, that are regulated by the federal aviation administration and that offer no special medical services or provide only transportation to patients or persons at the direction or under the supervision of an independent physician.

(3) "Board" means the Montana state board of medical examiners provided for in 2-15-1731.

(4) "Department" means the department of transportation provided for in 2-15-2501.

(5) "Emergency care provider" means a person licensed by the board, including but not limited to an emergency medical responder, an emergency medical technician, an advanced emergency medical technician, or a paramedic. An emergency care provider may have an enhanced endorsement to provide community-integrated health care.

~~(5)~~(6) "Emergency medical service" means a prehospital or interhospital emergency medical transportation or treatment service provided by an ambulance or nontransporting medical unit.

~~(6) "Emergency medical technician" means a person who has been specially trained in emergency care in a training program approved by the board and licensed by the board as having demonstrated a level of competence suitable to treat victims of injury or other emergent condition.~~

(7) (a) "Emergency response vehicle" means a vehicle used for the dedicated purpose of responding to emergency medical calls.

(b) The term does not include a vehicle used for an individual's personal purposes.

(8) "Nontransporting medical unit" means an aggregate of persons who are organized to respond to a call for emergency medical service and to treat a patient until the arrival of an ambulance. Nontransporting medical units provide any one of varying types and levels of service defined by department of public health and human services rule but may not transport patients.

(9) (a) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless.

(b) ~~The~~ Unless otherwise defined by rule for community-integrated health care, the term does not include an individual who is nonambulatory and who needs transportation assistance solely because that individual is confined to a wheelchair as the individual's usual means of mobility.

(10) "Person" means an individual, firm, partnership, association, corporation, company, group of individuals acting together for a common purpose, or organization of any kind, including a governmental agency other than the United States.

(11) "Volunteer emergency ~~medical technician~~ care provider" means an individual who is licensed pursuant to Title 50, chapter 6, part 2, and provides prehospital, interfacility, emergency medical, or community-integrated health care:

(a) on the days and the times of the day chosen by the individual; and

(b) for an emergency medical service other than:

(i) a private ambulance company, unless the care is provided without compensation and outside of the individual's regular work schedule; or

(ii) a private business or a public agency, as defined in 7-1-4121, that employs the individual on a regular basis with a regular, hourly wage to provide emergency medical or community-integrated health care as part of the individual's job duties."

Section 25. Section 61-2-503 , MCA, is amended to read:

"61-2-503. Emergency medical services grant program -- eligibility -- matching funds. (1) The department shall provide competitive grants to emergency medical service providers for acquiring or leasing ambulances or emergency response vehicles or for purchasing equipment, other than routine medical supplies, for any of the following purposes:

(a) training;

(b) communications; or

(c) providing medical care to a patient.

(2) A licensed emergency medical service may apply for a grant if:

(a) it has been in operation at least 12 months;

(b) it bills for services at a level that is at least equivalent to the medicare billing level; and

(c) a majority of its active emergency ~~medical technicians~~ care providers are volunteer emergency ~~medical technicians~~ care providers.

(3) An emergency medical service is ineligible for grant funding if it is either a private business or a public agency, as defined in 7-1-4121, and employs the majority of its emergency ~~medical technicians~~ care providers on a regular basis with a regular, hourly wage.

(4) An eligible emergency medical service applying for a grant under this section shall provide a 10% match for any grant funds received.

(5) The department shall award grants on an annual basis using the criteria contained in 61-2-504.

(6) Up to 5% of the annual appropriation for the program may be distributed for emergency purposes each year as provided in 61-2-507."

Section 26. Section 61-2-504 , MCA, is amended to read:

"61-2-504. Grant review criteria. When evaluating grant applications, the department shall consider the following factors:

(1) demonstrated need;

(2) size of the geographic area covered by the emergency medical service;

(3) distance from other emergency medical service providers in the geographic region;

(4) distance from the closest hospital;

(5) number of calls in the previous calendar year; and

(6) number of volunteer emergency ~~medical technicians~~ care providers on the active call roster."

NEW SECTION. **Section 27. {standard} Effective date.** [This act] is effective July 1, 2019.

- END -

Appendix 3

Hospitals with Emergency Rooms or Departments, Emergency Care Providers, Ambulance Services, Home Health by County

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	Para-medic 6/15/2 018	Ambulance / Related units on file with DPHHS	Home Health
	Barrett Hosp. CAH-Dillon	20	8	7	1	13 (10)	12 (9)		Dillon-AV (cm'ty vol)	
			(2 RNs)			1+1 Dell (4)	1 (3)		Lima-RFD - volunteer	
Beaver-head			(1 RN)			1	4 (5)		Polaris-FV	
						2	3		Wisdom-AV (cm'ty vol)	x
		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	
		2	4		2	6(6)	11(9)	1(2)	Chinook-AV	
			(2RNs)			1 Zurich (6)	(2)		Fort Belknap-Tribal Vol.	x
Blaine		1	2(1)			6 + 1 Hays(3)	4(6)		Harlem-MA	
					1 Hogeland+1 Turner	4	2		Hogeland-AV	
Broad-water	Health Cntr-Townsend	2		3	1 Toston + 1 Townsend	13+2Toston +1Winston(12)	2(3)	3(2)	Townsend-AV	2
		1	1(1 RN)		1	3+1 Edgar (10)	1	1(1)	Bridger - FV (cm'ty vol)	
						5				
Carbon		1				13Joliet +1Boyd (14)	0 (1)	0 (3)	Joliet -AV (cm'ity vol)	
	Red Lodge CAH	14	(3 RNs)	2	1	23Red Lodge + 1Belfry+ 7Roberts(24)	10 (9)	6 (4)	Red Lodge-FM	x

EXAMINING MEDICAL SCOPES OF PRACTICE TO BETTER SERVE COMMUNITIES & VETERANS

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	Para-medic 6/15/2018	Ambulance / Related units on file with DPHHS	Home Health
Carter		0	1	2	1Boyes	10+1Alzada, 1Hammond (11)	1 (1)		Ekalaka-AV	
Cas-cade		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 (aprn)	2
Chou-teau				3		10 + 3 Loma (10)	(1)		Big Sandy-AV (cm'ty vol)	
	CAH-Fort Benton	1	3+2Flo weree +1Cart er		1	10 + 3 Carter+1 Sq.Butte(12)	5(5)		Fort Benton-AV cm'ty vol	x
						5 + 4 Highwood (6)	(2)	1	Geraldine-AV cm'ty vol	
Custer	CAH-Miles City	20		6		13 + 1 Ismay (10)	6 (3)	4 (3)	Miles City F-Rescue-FP	x
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)	x
						4 (6)	(3)		Richey-AV (gov't vol)	
Deer Lodge	Community Hosp. of Anac. CAH	16	10	2	3	6 (2)	15 (10)	1	Anaconda-FP	x
Fallon	CAH-Baker	5	1	3		7 (6)	4 (3)		Baker-AM (gov't mixed)	x
Fergus		1	1			1CoffeeCrk (11)	9 (2)		Denton-AV (cm'ty vol)	
					2	7 (6)	3 (3)		Grass Range-AV (cm'ty vol)	

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	Para-medic 6/15/2018	Ambulance / Related units on file with DPHHS	Home Health
Fergus, cont'd	CAH-Lewistown	22	(2 RNs)			22+3 Hilger+ 1Moore+ 4Roy (12)	15 (10)	5 (9)	Lewistown-AP	x
							2			
						(6)	2 (2)		Roy-AV (cm'ty vol)	
						3 (6)			Winifred-AV (cm'ty vol)	
Flat-head		14	9			20 (12)	7 (9)	2 (13)	Bigfork-MF	2
		13	8 +1Hungry Horse		6	17+3Coram, 3W.Glacier, 2HungryHorse (4)	6 (2)	14 (6)	Columbia Falls-AP	
									Creston-FV (nontransp)	
			(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 Kalispel + 4 Smith Valley)	S.Kalispell-FV Kalisp-Smith Valley FV/AV Kalispell-FP/AP West Valley -FV	2
		6	1	4		12 + 2 Somers (11)	5 (5)	3 (5)	Lakeside-QRU-V (cm'ty vol)	
		2	1 + 1Kila		2 Kila + 2 Marion	1 Kila + 15Marion (15)	4 (2)		Marion FDist-M	
				1		2	1		Olney FV/AV	
	CAH-Whitefish	73		13		25 (3 Whitefish, 12 Big Mntn)	7 (1 Wh'fish 6 Big Mntn)	17 (17 Whitefish, 2 Big Mntn)	Whitefish City-FP Whitefish BigMntn-FP	
Gallatin		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+26 AP)	Big Sky-FM + AP (private)	

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	Para-medic 6/15/2018	Ambulance / Related units on file with DPHHS	Home Health
Gallatin cont'd	Bozeman Health Deac. Hosp.	274	86	68	14	345 (17)	23 (8)	38 (29)	Bozeman-AP	3
		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.Yellow-stone FDistM	
Garfield	CAH-Jordan			2		6 +1Cohagen (6)	6 (12)		Jordan-AV (cm'ty vol)	x
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 (cm'ty vol)	x
Golden Valley					1	5				
		1				1 (4)	2 (1)		Ryegate A-QRU-V (c'mty vol)	
Granite			1			1 + 1 Hall (3)	6 (7)	(1)	Drummond-AV (cm'ty vol)	x
	Med Cntr-Phillipsburg	2		1	2	8 (2)	5 (6)		Philipsburg-AV (cm'ty vol)	
Hill	Northern MT Hosp-Havre	28	12	5	1 Gildford + 3 Havre	11+4 K-G,3Hingham (9)	12 (8)	2	Havre-FP	x
			1+ Box Elder			2 Box Elder (2)	(5)		Rocky Boy's-Box Elder AP	
			(1 RN)		2	2	(11)		Rudyard-AV (gov't vol)	
Jeffer-son			1	1		4 (1)	8 (4)	1	Boulder-AV (gov't vol)	2

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	Para-medic 6/15/2 018	Ambulance / Related units on file with DPHHS	Home Health
Jeffer-son, con't			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 (cm'ty vol)	
Judith Basin			1			5 + 1 Moccasin	3			2
						2Geyser 2Raynesford	2	1	Raynesford /Geyser QRU-V	
						6 (6)	2 (11)	1 (1)	Stanford-AV (cm'ty vol)	
Lake			2 (Big Arm)	1		13 (12)	3 (3)		Arlee FV	
	CAH-Polson	25	1+	6	2+4Dayton	17 + 3 Dayton (14)	4 (5)	8 (21)	Polson/ Ronan/ St. Ignatius - AP (ambulance staff listed under Polson)	2
	CAH-Ronan			5		8	2	3		
						3 + 2Charlo	0	2		
Lewis and Clark						2 (3)	4 (4)		Augusta AV (cm'ty vol)	2
			6	3	5	25	5	2		
	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 (cm'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 (cm'ty vol)	x
	CAH-Libby	18		7	5	14 + 3 Rexford (9)	14 (8)	3 (1)	Libby-FM/AM (cm'ty vol)	
					1	16 (15)	2 (4)	2 (3)	Troy-AM (cm'ty vol)	

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	Para-medic 6/15/2 018	Ambulance / Related units on file with DPHHS	Home Health
Madi-son	CAH-Ennis	2	3		2	6 +2Cameron+4 McAllister(9)	8(8)	1(2)	Ennis-AV cm'ty vol	
		1-Pony			1	2Alder+ 4Cardwell+ 1Norris				
	CAH-Sheridan	3	(1 RN)	3		9 (10)	(2)	3 (4)	Sheridan-AM	
		1 + 1		1		7	7	1		3
Mc-Cone	CAH-Circle			2		16+ 2Brockway+ 1Vida (11)	6 (5)		Circle-AV (cm'ty vol)	x
Meagher	Med Cntr-Wh.Sulphur Springs					9+ 1Martinsdale, 1Ringling (19)		1	WhSulphur Springs-AV (cm'ty vol)	x
Mineral	CAH-Superior	1	2+	3	1 St. Regis	9+ 2Alberton+2St Regis (10)	7 (9)		Superior-AV (cm'ty vol)	x
Mis-soula					1	9 Condon (8)			Condon/ Swan QRU-V (cmty vol)	
				0		17 + 2DeBorgia,3 Huson (23)	7 (8)	2 (6)	French-town FM	
	Community St. Patrick			74	6	255+6 Bonner, 10 Clinton, 2Greenough, 1Milltown, 1Potomac (32)	46 (3)	60 (27)	Missoula-AP	2
		5			1	16 (12)	1(1)	2(3)	Seeley Lake-FM	
Mussel-shell	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	2
		33		7	1 Livingston + 2 Wilsall	30 + 4Wilsall+ 3ClydePrk(11)	5(1)	(14)	Livingston-FM	
Pet-roleum						7(10)	5(8)	(1)	Winnett-AV	
Phillips	CAH-Malta	1	(6 RNs)	1	1 Loring	15 + 1 Dodson (14)	2(7)		Malta-AV (cm'ty vol)	x

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	Para-medic 6/15/2 018	Ambulance / Related units on file with DPHHS	Home Health
Phillips cont'd				1		1	2			
Pon-dera	Pondera Med Cntr-Conrad	4	2 +1 Brady	2	1	7(10)	3(6)	3(8)	Conrad-AV (cm'ty vol)	2
		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	x
Powell		1			2	1+ 1Elliston,1 Helmville (5)	3(3)		Avon VF-QRU (cm'ty vol)	2
		5	3+1 Gar-rison	3		5(9)	4(4)	(1)	Deer Lodge-AV (cm'ty vol)	
Prairie		0		1		4(3)	4(7)	(1)	Terry-AV (comm'ty vol)	
Ravalli			1	1	1 (Conner)	6	6	3		
			8	4	1	10 + 17 Lolo	7	7	Florence F-QRU-V	
	Marcus Daly Mem Hosp. CAH	45	11	5		21+1Pinesdale (13)	7(19)	9(28)	Hamilton-AP	2
					1 Corvallis+ 1Stevensvil.	27+ 8Corvallis (13)	11+4 Corval-lis 3)	9	Stevensville -FV	
			7+1 Cor-vallis	2		6(5)	(6)	(4)	Victor FV	
Rich-land			3			2	1			
	Health Cntr-Sidney	12	1+1 Crane	3		12 4 Lambert+ 3Savage (21)	12(21)		Sidney-AV	
Roose-velt	CAH-Culbertson		(1 RN)	2		5 +5Bainville (9)	4(9)	(1)	Culbertson-AV	
							2			
	CAH-Poplar		(1 RN)			8 WolfPoint+ 5 Poplar+ 2 Brockton (28)	1 4 (9)		Poplar/WolfPoint-AP	
	CAH-Wolf Point		1 Brock-ton	1	1			1(1)		
Rose-bud			1	3	14	24(3)	6(3)	2(1)	Colstrip-AV (cm'ty vol)	

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Rose-bid, con't	Rosebud Health Cntr-Forsyth		1	2	3	14(13)	3(2)	3(2)	Forsyth AM	x
			1+1 Ash-land			4+4 Ashland (5)	3(4)	(3)	Lame Deer-AM Tribal	
					1	1			Rosebud-AM	
Sanders						1(2)	4(3)	(1)	Hot Springs-AV (cm'ty vol)	x
					3 Dixon + 1 Noxon	3+2 Dixon+ 3Heron+3TroutCrk (8)	3(2)	(1)	Noxon-AV (cm'ty vol)	
			1 Dixon	3		11 +1 Paradise(10)	4(4)		Plains-AV (cm'ty vol)	
	CAH-Thompson Falls	1	(1 RN)	4	1	7(6)	3(2)	(1)	Thompson Falls-AV (cmty vol)	
Sheri-dan						2 + 2 Dagmar	0			
	CAH-Plentywood	1	(1 RN)		1	7+ 1 Outlook(14)	4(7)	(1)	Plenty-wood -AM	
		0				1	0			
Silver Bow	St. James-Butte	73	33(2 RNs)	16	4	64 + 1 Melrose (11)	21(7)	7	Butte-AP	3
Still-water		0	(1 RN)	2	3	7 + 2Fishtail+2Nye(11)	2(2)		Absarokee-AV (cm'ty vol)	
	Stillwater Cmnty Hosp. CAH	3	1	5		15 + 1 Reedpoint (17)	2(6)	5(11)	Columbus-FM	
						9 (7)		1	Park City-AV (cm'ty vol)	x
Sweet Grass	Pioneer Medical Center	3	2 (1 RN)	2	1	16 + 1 McLeod (15)	7 (10)	4(4)	Big Timber-AV	x
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)	x
		2	2	2 + 1	2 Power + 2	6+7Power+8	0 + 7			
Toole	Shelby Med Cntr					1 Oilmont	1			
		4		1		8(5) + 3	6(9)+1		Shelby-AM	

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Trea-sure		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 (cm'ty vol)	
Wheat-land	CAH-Harlowton		4			10(17) + 6			Harlowton-AV (gov't)	
Wibaux						8(6)	3(4)		Wibaux-AV (cm'ty vol)	
Yellowstone	Billings Clinic St. Vincent's-Billings	622	121 (1 RN)	141	3	1 Action + 221 Billings+ 4 Broadview (30)	30 (2)	96(38)	Billings-AP	x
		10	8	1	1	18 (10)	8(6)	1(2)	Laurel-AV (cm'ty vol)	
						(5)	(1)	(7)	Lockwood FM	
		1	1 Hunt-ley	1		1 Worden+ 1Huntley+ 9Shepherd (4)	3(5)	3	Worden-AV (cm'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 Health and Human Services.

NOTE 2: Abbreviations: FV = Fire Dept. Vols.; AV = Ambulance Vol.; AP= Paid Ambulance; FP = Paid Fire Dept.; QRU - quick response unit; MA or MF=mix of paid and volunteers on ambulance, fireunit; FSA=fire service area; Fdist=Fire District. Ambulance units may be governmental non-fire, hospital-based, community nonprofit, or private nonprofit.

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