Testimony
Interim Health Services Committee
Tuesday, January 10, 2012
North Dakota Department of Health

Good afternoon Chairwoman Lee and members of the Health Services Committee. My name is Tom Nehring, and I am the director of the Division of Emergency Medical Services and Trauma for the North Dakota Department of Health. I have been asked to provide a report on the status of emergency medical services in the state.

In the final report from SafeTech Solutions as a result of the Rural EMS Improvement Project, it is noted that the authors believe that "rural out-of-hospital emergency medical services (EMS) in North Dakota faces a growing and potentially dangerous crisis."

EMS developed in rural North Dakota without state or regional planning and without a mandate for the provision of EMS. Ambulance services were created locally based on perceived need, local interest and resources. In populated areas, if a service completes approximately 650 or more revenue producing runs, reimbursement for medical transportation funds the ambulance service without additional subsidies. In rural areas, where volumes of medical transports are low, subsidies are needed. The subsidies include donations, local tax revenues and volunteer labor.

If all of the ambulance services in the state were homogenous, tackling these challenges could occur in much the same manner for all of them. However, each ambulance service is unique depending significantly on their geographic location within the state.

The oil boom area of the state brings it own challenges. A demand has been created for responses from ambulance services they have never encountered before, additional specific training is needed, and environmental challenges need to be overcome. When contrasted with those areas of the state that have aging populations and an out-migration of people, the problems encountered at the extremes in these areas differ radically.

In the past, the legislature has allocated monies for both training of ambulance personnel and a staffing grant. In the immediate past biennium, there was $2,250,000 allocated for the staffing grant and $1,125,000 for the

training grant. In the 2011 legislative session, the training grant was decreased for this biennium to $940,000. For the first year of the current biennium, funds in the amount of $1,250,000 were allocated for staffing grants. In the second year of the biennium, there is $3,000,000 allocated for ambulance operations. The money previously known as the staffing grant funds will now be combined with the ambulance operation funds, so the base funding for the next biennium will be $4,250,000.

In North Dakota, 14% of the ambulance services operate with fully paid staff and 86% of the services remain primarily volunteers. The largest subsidy in rural ambulance services is volunteer labor. To replace the volunteer subsidy would cost in excess of $31 million per year.

Ambulance services are the backbone of out-of-hospital EMS in the state. They are the most active component of out-of-hospital EMS, responding to more than 61,000 calls annually. They are an essential ingredient of every call for help, providing both treatment and transportation as needed.

An assessment during the Rural EMS Improvement Project found that:

- The recruitment of volunteers is significantly more difficult than a decade ago.
- Volunteers are aging and not being replaced by new volunteers.
- Forty-six percent of people listed on service rosters are inactive and only 38% of members listed on rosters were reported as frequently taking calls. Thirty-five percent of ambulance services have difficulty filling schedules during certain times of day or week.
- The need to provide financial incentives for volunteers to be on a schedule for calls and to respond on calls is increasing.
- Some EMS workers are taking more than 120 hours of call time per week.
- Some services reported having two to five active members remaining in their services.
- Some services may close, which extends the burden to other services within their area; many of which do not want a larger service area.

The decline in volunteerism and the declining volunteer subsidy is resulting in a significant change in how rural EMS is envisioned, valued, funded and maintained in North Dakota. In North Dakota and throughout the Great

Plains region, there is no indication the trend in declining EMS volunteerism will stop.

Some general statements could be made that contribute to the present EMS situation:

- There is no mandate for EMS in the state for either the provision of or funding of services (no responsible entity).
- Individual services do not work together to form a true system.
- Overall statewide funding needs for essential EMS resources is not defined. Given the social, political and financial climates what solutions are possible?
- This is a crisis which needs attention in all areas, not just funding.
- These are complex issues and easy solutions are elusive.
- Local EMS leaders/managers are keys to success.
- How do we replicate the rural ambulance services that are doing well?

There are a few rural ambulances that are doing well. The characteristics of successful rural services are as follows:

- They are led by engaged, trained, dedicated and rested leaders.
- They maintain high professional standards.
- They create recruitment and retention friendly cultures.
- They tell compelling stories. These stories are about the importance of the service, the sacrifice made by volunteers, and the changing needs of rural EMS.
- They use a call schedule.
- They practice safe and humane scheduling.
- They procure adequate funding for the service.
- They maintain facilities, vehicles and equipment.

The 2011 Legislative Assembly appropriated $4,250,000 per biennium for ambulance services in North Dakota. House Bill 1044 also called for the formation of an EMS Advisory Council. It is the function of the council to represent the EMS industry and make recommendations to the Department of Health with regard to establishment of funding areas and criteria to be used to determine a funding level for each funding area. To this point, the EMS Advisory Council has been meeting on a monthly basis, has determined the funding areas within the state and is working on criteria to be utilized for the allocation of money to the funding areas. The criteria can be

utilized to allocate money to either an individual ambulance service or a group collaborating to increase the EMS viability in their region.

We have provided you with a copy of the final Rural EMS Improvement Project report entitled “A Crisis and Crossroad in Rural North Dakota Emergency Medical Services.” This document, along with others, is available on the Department of Health’s website should you have further interest.

This concludes my testimony. I am happy to answer any questions you may have.