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Testimony: Community Paramedic Study
Senate Concurrent Resolution No. 4002
Health Services Committee
Wednesday, October 30, 2013; 1:00 p.m.

Good afternoon, Madam Chair and members of the committee. My name is Sherm Syverson, and I am the Executive Director of F-M Ambulance Service in Fargo. I am here today in support of the community paramedic initiative in North Dakota and I'd like to present 2013 ambulance call data from the top 10 most frequent North Dakotan users of F-M Ambulance Service to help illustrate the need to study and implement common-sense changes to the way emergency medical services (EMS) personnel deliver healthcare to people of our state.

Beginning January 1, 2013, through today, the top 10 North Dakotan users in F-M Ambulance's service area have called 911 a total of 293 times. The top five of these individuals account for 200 calls and transports to emergency departments; the top two have each called for an ambulance more than 50 times this year. The year to date total of the combined bills for these individuals is nearly $200,000. Three of the 10 have no insurance and we have written-off a combined $257,800 of their bills over the past decade. Another three are enrolled in Medicare plans, two in ND Medical Assistance, one has private insurance and one has Veteran's Administration benefits.

The reasons the top 10 frequent users call for EMS services help clarify gaps in the current healthcare delivery model for this group. Their primary reasons for calling an ambulance are mental health-related issues (50%), diabetes complications (20%), seizures (20%) and substance abuse (10%). Substance abuse is the secondary reason for four of the individuals. When the top 50 users of F-M Ambulance Service are compared (34 North Dakotans, 16 Minnesotans), a total of 32 have either substance abuse or mental health-related issues listed as their primary reasons for requiring EMS interventions.

It is important to emphasize that high-frequency users of the EMS systems in North Dakota not only burden ambulance services, but also local and state law enforcement agencies, fire departments, behavioral health professionals and emergency departments. There are real costs associated with providing this level of care to a small portion of the population.

I'm hopeful the community paramedic study produces recommendations that address using existing EMS resources to reduce emergency department visits and hospital re-admissions. I ask for your ongoing support of the community paramedic initiative and the study so we might challenge the status quo, investigate the current environment, identify possible solutions to gaps in healthcare services, and implement policies that work for North Dakota. Care must be taken to address scope of practice concerns, avoid unnecessary service duplication and develop a plan for reimbursement in order to sustain the initiative.

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