Testimony
Health Services Committee
July 31, 2013
North Dakota Department of Health

Good morning, Chairwoman Lee and members of the Health Services Committee. I am Tom Nehring, Director of the Division of Emergency Medical Services and Trauma of the North Dakota Department of Health. I am here to provide information about the study coming from Senate Concurrent Resolution 4002.

The concept of community paramedics, also known as Community Health Emergency Medical Services (EMS), is to use portions of the EMS workforce to address community health and medical needs that communities currently do not have the resources to address. The program would build on existing skill sets to deliver primary care, public health, disease management, prevention and wellness, mental health and dental care services. Specific examples of these services could include assessments, chronic disease management, blood draws, diagnostic cardiac monitoring, fall prevention and medication reconciliation. These services would be delivered in a highly mobile environment by trained EMS providers in places such as homes, schools and places of employment where the services are currently not available.

A Community Health EMS program can create major improvements in North Dakota while reducing health-care costs. The program has the potential to supplement and strengthen health care currently being provided to North Dakotans in rural and urban areas. Below are three examples of how the use of Community Health EMS programs would benefit citizens of North Dakota:

1. The provision of services in rural communities where no clinical services or hospitals currently exist and to fill gaps within the community healthcare system that may exist. A Community Health EMS program in this environment will increase access to health care, provide for early detection of problems to avoid more complex issues, while reducing travel costs for the patients as well as clinical expenses.
2. Reduction in unnecessary and expensive visits to emergency departments. These savings would be achieved by providing a screening process by the EMS system, under medical direction, and the delivery of services in the field when it is safe and effective to do so.
3. Sustainment of the existing EMS system by creating revenue streams that are not exclusively tied to the transport of patients to or from medical facilities. Under the current system design, EMS providers have substantial periods of time in which they are not delivering services as they wait for the next emergency call and revenue is only generated when patients are transported. The Community Health EMS concept would allow EMS to provide revenue

generating non-emergency care in the community while maintaining the capability to respond quickly to emergency calls.

A Community Health EMS model can be beneficial because it promotes coordinated and integrated care by the EMS system with physicians, nurse practitioners and physician assistants, hospitals, home health agencies, long-term care facilities, and public health departments. This model creates a team approach to health care from home through the entire health care continuum. A Community Health EMS program does not replace current health-care systems or positions, change the current defined scope of practice of EMS personnel, remove patient populations from health-care providers or decrease the level of care provided.

The North Dakota Department of Health is moving forward with a small pilot program for Community Health EMS as approved by the 2013 Legislative Assembly. A Community Health EMS subcommittee has been formed under the Emergency Medical Services Advisory Council (EMSAC). We look forward to working with legislative management on this study as the pilot project is implemented.

We have attached a fact sheet that provides additional information about Community Health EMS programs. I would be happy to answer any questions you may have.