

Testimony
Pursuant to Section 7 of 2015 SB 2048
Legislative Management's Interim Human Services Committee
Tuesday, March 8, 2015
F-M Ambulance Service, Inc.

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 located in Fargo.

F-M Ambulance Service (FMA) is the largest ambulance operator in North Dakota responding to more than 26,000 calls for service annually. Of those calls, one-third involve behavioral health components. Common calls include substance abuse, depression, suicidal ideation, anxiety and depression. Too often psychological maladies are often accompanied by chronic physical illnesses. Many patients are well-known to EMS, healthcare providers, law enforcement and social services due to their frequent use of emergency services and 911 dispatch centers.

With regard to emergency medical services (EMS) some notable progress has been made over the past two legislative sessions. The ability for physicians to communicate remotely with EMS providers on scenes of behavioral crises has improved and implementation of a community paramedic pilot program in Fargo was instrumental in reducing unnecessary emergency room visits of high-frequency users by 40% in the patient population being cared for by FMA's Community Paramedic Program. But these two small examples of positive momentum are somewhat overshadowed by ongoing gaps in behavioral health coverage in North Dakota.

The most glaring problems seen by EMS agencies include capacity to care for people locally, the inability of ambulance services to be compensated for transporting behavioral health patients to non-emergency room destinations, a lack of behavioral health practitioners available to respond quickly 24/7, and barriers inhibiting—and in some cases preventing—the sharing of health information between agencies, practitioners and institutions.

These issues are intertwined and have commonality in their root causes. Capacity to care for behavioral health patients manifests in a lack of beds available and not enough trained professional staff. Without financial incentives to support behavioral health providers, patients will continue to be shuffled around ND in order to find treatment facilities able to care for them. FMA has seen an increase in out-of-town behavioral health patient transfers from 49 in 2011, to an all-time high of 175 in 2015.

With regard to acute care, if ambulance services cannot secure reimbursement for transporting patients to alternative care locations such as a behavioral health clinic the default destination will continue to be local emergency departments. Increased funding for crisis teams should be considered as well as infrastructure to support them. The teams should be multi-disciplinary and be required to develop a local and/or regionalized plan.

In closing, EMS providers including local emergency medical responders, volunteer and professional EMT's, paramedics and community paramedics should be provided financial and non-financial (training, equipment & legal) support to deliver behavioral health care.

Thank you for the opportunity to testify and I welcome any questions you may have.