

The North Dakota Emergency Medical Services in Crisis, 2026

1.1 Administrative Challenges: Recruitment and Retention Crisis

Workforce recruitment and retention crisis: Services are at critical staffing levels. Long on-call hours, low pay and burnout make it hard to maintain a stable workforce. Low-volume services have trouble attracting and keeping qualified EMS staff. High volume services are struggling for recruitment as well and deal with low compensations levels. Competition for key medical talent like paramedics continues to inhibit retention.

Workforce stress and burnout: Compensation levels are too low considering the knowledge, skills and abilities that are expected to do the job, the high stress levels and the serious consequences of the work not being done appropriately. Access to an EAP is varied, and access to a counselor specialized to work with the trauma experienced by first responders is also varied.

Ambulance services are only reimbursed for loaded time. Meaning, a volunteer in Bowden takes a call from neighboring jurisdiction to the nearest medical facility – in Bismarck: 3 hours there and 3 hours back. The service is only reimbursed for the 3 hours there.

1.2 Administrative Challenges: High Fixed Costs and Complex Billing

Financial inefficiency and sustainability risk: Ambulance must be ready and equipped regardless of the volume of calls. Each service must maintain vehicles, equipment, training and meet regulations. High fixed costs spread over few runs create financial strain and make services rely heavily on subsidies or volunteers. At 3% growth year over year it would take 60 years to buy a new ambulance.

Financial and operational challenges: Transporting non-emergency patients by ambulance is expensive and usually not fully reimbursed. Reimbursement for ambulance services is not made for non-emergency care even if this is the level of care needed by the patient. Some patients believe it to be cheaper to call the ambulance than to go to a clinic

or call the Doctor. Additionally, there is no current billing stream for community paramedics. Medicaid and Medicare coverages are significantly under reimbursed, leading to long and arduous reimbursement battles. Some areas see as high as 90% Medicaid and Medicare populations.

Workforce stress and burnout: Responding to many low-acuity calls contributes to EMS worker fatigue and job dissatisfaction. Over time, this leads to higher staff turnover and weakens the overall system.

2. There is Currently a Single Response Type, Regardless of the Severity of Need

Mismatch between urgency and demand: Ambulance services are designed to respond quickly to life-threatening emergencies, yet only about six percent of 911 calls involve truly critical situations. This leads to significant resources being used for non-urgent cases.

Inefficient use of limited EMS resources: Highly trained personnel and advanced medical equipment are often dispatched to calls that do not require emergency care. This reduces availability for genuine emergencies and increases operational costs.

Limitations of the Current 911 Response System: The current 911 system does not effectively distinguish between urgent and non-urgent calls. As a result, Emergency Medical Services resources remain stretched thin and less efficient, and patients often receive unnecessary or inappropriate services.

Lack of Alternative Clinical Assessment and Care Options: Emergency Medical Services lacks the ability to contact a higher-level medical provider on a twenty-four-hour basis to assist with assessment of patients who do not meet emergency protocol screening criteria. It also does not have the capability to deliver lower levels of non-emergency care through services such as those provided by a community paramedic or community health worker.

Absence of Non-Emergency Transportation and Rural Service Gaps: Emergency Medical Services does not have the ability to provide non-emergency medical transportation on either a scheduled or unscheduled basis. These types of services are not

Areas across the state without a clinic or hospital means ambulances are often tasked with basic medical care, sending a \$500K piece of equipment and two providers to check blood pressure in Billings County.

available in many rural communities, where the ambulance service is often the only accessible medical provider.

Extended response and transport times: Large geographic areas with limited staff often lead to longer response and transport times. This can delay critical care and increase risks for patients with serious emergencies. In one service, 50% of their calls are long-distance transfers to Dickinson, Minot, with mental health transported all the way to Fargo.

3. Rural Nature Results in Low Call Volume, Limiting Exposure

Low Call volumes and skill decline: Many rural ambulance services handle very few calls, which limits the opportunities for providers to keep their medical skills sharp. Rare exposure to serious emergencies can reduce readiness and affect the quality of care. Training opportunities are less frequently available and more expensive per EMT in rural areas

Low call volume -> skill decline -> reduction in quality of care

System fragmentation and inconsistent care: Having many low volume ambulance services leads to duplicated resources and difference in capabilities. This fragmentation reduces overall efficiency and creates uneven quality of care across the state. As services deprecate the jurisdiction sizes, and response times, grow.

Many Medical Directors are uninvolved: There is inadequate physician-led medical direction for many of the ambulance services.