

Initial report from the task force on Transportation of nonemergency behavioral health patients

During the regular session of 2019 in the 92nd General Assembly, House Bill 1710 created a Task Force to make recommendations to the legislature and policy makers concerning the transportation of nonemergency behavioral health patients in Arkansas.

During the task force's discussions, we made a clear distinction in our recommendations, from the Division of Medical Services (DMS) Arkansas Medicaid Non-Emergency Transportation (NET) program which provides eligible Medicaid beneficiaries, who have scheduled appointments, with transportation for medical services. These types of transports are not considered the types of non-emergency transportation events discussed in this Task Force, nor part of this report or recommendations.

Through initial meetings, it quickly became clear this is a true and very complex issue being faced by many in our state today. It is apparent that, while appropriate transport for Arkansans with behavioral health needs is the issue, solutions may be different depending on whether the needed transport is identified at the community level (within a correctional facility, on the side of the road, in a home, at a public or private event, etc.) or identified within an hospital emergency department or other mental healthcare facility (examples of facility-to-facility transports).

While the introduction of Crisis Stabilization Units in a very limited number of areas in the state has helped some, the problem is much larger than the Task Force had anticipated. By using inappropriate modes of transportation, the State is putting at risk the lives of EMS and law enforcement personnel, as well as the patients themselves, and all payers may be spending much more than necessary for the transport.

As the Task Force dug deeper into the potential solutions, several factors were discovered that must be addressed. These include, but are not limited to the following:

- *Mental Health Resource Identification* – At present, there is no statewide map of public and private mental health resources. This map must include data that depicts mental health professionals by provider type, treatment expertise, treatment availability.
- *Patient Placement Opportunities* - Once that map is created, it must be appropriately updated, maintained, and accessible by law enforcement, mental health providers, other health care providers, and anyone with the ability and authority to transport patients with behavioral health needs to the most appropriate facility for that patient.

- *Facility Acceptance* – The rules for how facilities receive patients who are identified as needing transportation to that mental health resource must be transparent and equitable. For example, the current system for a facility-to-facility transfer (emergency room to another hospital more equipped to efficiently treat a particular patient at a particular time) requires a doctor-to-doctor conversation. Requirements for transporting patients from the community to a community mental health resource other than a hospital (like a Community Mental Health Center, Crisis Stabilization Unit, Federally Qualified Health Center, Residential Treatment Facility, or to a public or private provider) are mental health resource specific and must be streamlined for consistent patient care throughout the transport process.
- *Timeliness of Transfers* – For facility-to-facility transports, entities transporting patients are at the mercy of the both the entity requesting a transport and the entity receiving the transport. While physician involvement is imperative, ensuring that communications can happen more efficiently is paramount (see resource allocation below). For community to facility transports, entities transporting patients are at the mercy of the receiving mental health resource’s ability to accept the patient. While a statewide communication system can possibly help with this issue, this will require complete buy-in from both public and private facilities or a statutory requirement for all to participate.
- *Resource Allocation* – When long-distance emergency behavioral health patient transports are requested in the middle of the night, law enforcement and EMS services are put in the precarious position of ensuring that resources are available to their primary geography before they are capable of leaving their service area to respond to the needs of the patient needing a long-distance transport. Hospital emergency rooms, correctional facilities, and even community mental health resources also have competing priorities for scarce resources when they have requested an emergency transport.
- *Custody issues* – There is a great distinction between a voluntary and non-voluntary transport for law enforcement and the medical community. Regulations and laws require different levels of care based on this distinction, alone.
- *Appropriate Reimbursement* – Government payers (Medicaid, Medicare, and TriCare) reimburse providers at rates less than the cost of providing care to mental health patients. Many commercial plans do not adequately cover mental health services for patients.
- *Liability* – We have determined that liability is something that the Task Force will have to address.

The Task Force reached out to other states and learned of several pilot programs, but no state seems to have come up with a true solution. Below is a list of some of the additional issues that will need to be addressed:

- Provider and public education
- Regulatory oversight
- Payer data
- Best type of transport – Law Enforcement, EMS or a third, hybrid type
- Available beds
- Funding including how much funding will be needed and for how long
- The development of a centralized communication center

While we understand the Task Force statutorily must end, we also understand that many of the recommendations included in this report will need additional work before we would feel comfortable asking members to make major statutory changes. Therefore, the Arkansas Department of Health has agreed to continue staffing this Task Force, and the legislative members, Senator Jimmy Hickey and Representative Mark Perry, along with the other members of the Task Force have agreed to continue working on the issues, and will bring an additional report next Fall.

The Task Force is working with Arkansas Insurance Providers, EMS professionals, the Arkansas Center for Health Improvement and law enforcement to try to establish the total number of transports as well as the costs of those transports. This data is not fully compiled as of the time of this report.

The statistics for behavioral health emergencies are staggering: 19.1% of U.S. adults experienced mental illness in 2018 (47.6 million people). This data represents 1 in 5 adults. 4.6% of U.S. adults experienced serious mental illness in 2018 (11.4 million people). These numbers represent 1 in 25 adults. 16.5% of U.S. youth aged 6-17 experienced a mental health disorder in 2016 (7.7 million people) 3.7% of U.S. adults experienced a co-occurring substance use disorder and mental illness in 2018 (9.2 million people) and these numbers are sure to increase. ("Mental Health by the Numbers," 2019)

Currently, in Arkansas, non-emergency behavioral health patients are transported for the most part by Emergency Medical Services (EMS) and law enforcement. These patients at the time of their transfer for either admission or evaluation are often a danger to themselves or anyone else. Transports are made in sophisticated advanced life support ambulances with highly trained medical providers when many of these patients are not in a medical crisis that requires advanced medical care during the transport. The same holds for law enforcement officers who transport non-emergency behavioral health patients to local jails, or out of their jurisdiction for

hours at a time in their patrol cars, when in both cases, the patient needs only safe and appropriate transportation to their admitting medical facility. The cost for current practice is difficult to capture in the law enforcement community as there is not a billing structure to take into account, staff hours, vehicle operations cost, and overtime coverage in the county that they are required to leave for extended periods and does not include costs associated with those patients taken to jail for evaluation and subsequent transport.

In some counties in Arkansas, EMS agencies utilize a large percentage of their staffing in transporting non-emergency behavioral health patients who may pose no safety risk, rather than responding to medical emergencies. Some ambulance crews and law enforcement officers can be gone up to 10 hours at a time taking patients from one corner of the state to the other. The current model in the long term is neither sustainable nor realistic.

There are also the safety concerns of both the EMS provider and patients transported. EMS providers when faced with a patient that no longer wishes to be transported, the EMS provider has limited options other than to stop and let the patient out of the ambulance, as they have no custodial powers. This places the patient in tremendous danger and a provider is in a challenging dilemma.

The following recommendations aim to reduce the stigma associated with a psychiatric crisis while also reducing the enormous cost of sending ambulances and law enforcement patrol vehicles long distances and protect both patient and provider. In addition, these alternatives could ease the pressure on local EMS and law enforcement, who spend thousands of hours each year transferring non-emergency behavioral health patients who pose little ~~or no~~ safety risk. In the end it will take patients, providers, payers, state agencies, and lawmakers working together to change the broken system of both non-emergency and emergency mental health transportation needs.

Potential Recommendations:

1. Assure that all non-emergency behavioral health patients receive the most appropriate form of transportation for their condition so that both law enforcement and emergency medical resources are not over-utilized and stay within their communities to provide emergency response.
2. Develop statewide protocols in conjunction with mental health evaluators, emergency medical services, law enforcement to determine what mode of transport is in the best interest of the patient.
3. Expand the state's unscheduled non-emergency medical transportation model and consider the addition of contracted organizations to provide general transportation for behavioral health patients. This will include the development of patient, provider, and vehicle safety requirements, as well as the establishment of some type of license for this type of transport through the EMS Section at the Department of Health, in conjunction with Law Enforcement Standards and Training.
4. Promulgate rules that address all aspects of non-emergency behavioral health patient transports, to include but not limited to provider training, vehicle safety, response times, and communication infrastructure.
 - a. A potential list of requirements may include those that transport non-emergency behavioral health patients in vehicles that are not ambulances or law enforcement patrol cars.
 - i. Age restriction based on a review of existing statutes and other sources.
 - ii. Hold a valid driver's license.
 - iii. Undergo an appropriate criminal background check.
 - iv. Ensure passengers are protected from harm, abuse, self-abuse, neglect, sexual incidents, serious injuries and other sources of immediate danger during transport.
 - v. Have an established plan to get emergency care.
 - vi. Be trained in effective communication skills with people who have mental illness.
 - vii. Recognize and plan for problematic behaviors in a therapeutic and safe manner.
 - viii. Know the statutes and standards for transporting patients. (To be developed)
 - ix. Transport patients in an approved vehicle.
 - x. Recording device for the protection of both the patient and provider.
 - b. Agencies that are responsible for the transport of patients will be required to develop rules, regulations and/or protocols around the type of vehicle, the

necessary equipment as well as the training required for those providing transportation services.

1. Provide drivers with vehicles that meet the standards below if transporting patients in wheelchairs. Vehicles must have:
 - i. An electrical or hydraulically operated lift mechanism or ramp with a non-skid surface.
 - ii. A means of securing a wheelchair to the inside of the vehicle to prevent any lateral, forward, backward or vertical motion of the wheelchair within the vehicle.
 - iii. A rear-view mirror that lets the driver see any passenger in a wheelchair.
 - iv. An emergency exit at the back of the vehicle.
2. The Task Force will work to develop an appropriate "Patient Bill of Rights"
5. Develop evidence-based statewide training for all Emergency Medical Service providers, law enforcement officers, and transport personnel responsible for the evaluation, and/or transportation of non-emergency behavioral health patients. This training should include some type of education that would be available to the public.
6. Create a sustainable statewide central communication center that receives calls for the coordination of the three rights for transportation, the right vehicle, the right route and the right schedule as well as vehicle tracking for all non-emergency behavioral health patients being transported across the state. The creation of a centralized call center would be effective in expediting the transfer process and thus reducing the time to admission to a behavioral health institution and decrease the overutilization of emergency departments, and unnecessary use of law enforcement jail resources. Many patients stay in the emergency department for hours; some even stay there for a few days.
7. Expand the mobile crisis plan that currently exists in many parts of the state.
8. Work with all payers to establish costs associated with current system to determine what potential savings could be used to help establish the new system. Additionally work with the receiving facilities to see what funds may be available there, while also exploring potential coverage mandates, if funds are available.
9. Provide for centralized data collection to ensure system sustainability, improvement, savings verification and cost avoidance.

Mental Health by the Numbers. (2019, September). <https://www.nami.org/learn-more/mental-health-by-the-numbers>

Task Force Members

- House Committee on Public Health, Welfare and Labor – Representative Mark Perry
- Senate Committee on Public Health, Welfare, and Labor – Senator Jimmy Hickey, Jr.
- Department of Health - Greg Brown
- Department of Human Services – Mark White
- Arkansas Hospital Association, Inc. - Shane Frazier
- Division of Medical Services of the Department of Human Services - Janet Mann (Paula Stone substitute)
- Arkansas Association of Chiefs of Police - Sgt. Charles Jones
- Arkansas Sheriffs' Association - Scott Bradley
- Association of Arkansas Counties - Mark Whitmore
- Developmental Disabilities Provider Association - Larry Stang
- Arkansas Shared Savings Entity – Robert Slattery
- Mental Health Council of Arkansas - Dianne Skaggs
- Arkansas Ambulance Association - Amanda Newton
- QualChoice - Randall Crow and Dr. Milton Hammerly
- Arkansas Health & Wellness - Jack Hopkins
- Arkansas BlueCross BlueShield - Hal Norman

