

**Progress Report on the Community Paramedic Mobile Crisis  
Management Pilot Program**

**Session Law 2015-241, Section 12F.8.(c)**



**Report to the**

**Senate Appropriations Committee on Health and Human Services**

**and**

**House Appropriations Committee on Health and Human Services**

**and**

**Fiscal Research Division**

**by**

**The North Carolina Department of Health and Human Services**

**June 1, 2016**

## **Introduction**

This report is submitted to address the interim progress report required in Session Law 2015-241 Section 12F.8.(c):

### ***COMMUNITY PARAMEDIC MOBILE CRISIS MANAGEMENT PILOT PROGRAM***

*SECTION 12F.8. (a) Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of two hundred twenty-five thousand dollars (\$225,000) for fiscal year 2015-2016 shall be used to continue the Department's community paramedic mobile crisis management program to divert behavioral health consumers from emergency departments by implementing a pilot of the thirteen programs across the State.*

*SECTION 12F.8.(b) The Department shall develop an evaluation plan for the community paramedic mobile crisis management pilot program based on the U.S. Department of Health and Human Services, Health Resources and Services Administration Office of Rural Health Policy's, Community Paramedicine Evaluation Tool, published in March 2012.*

*SECTION 12F.8. (c) The Department shall submit a report to the Senate Appropriations Committee on Health and Human Services, House Appropriations, Health and Human Services, and the Fiscal Research Division by June 1, 2016, on the progress of the project and the Department's evaluation plan.*

*SECTION 12F.8. (d) The Department of Health and Human Services shall submit a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016. At a minimum, the final report shall include the following:*

- (1) An updated version of the evaluation plan required by subsection (b) of this section.*
- (2) An estimate of the cost to expand the program incrementally.*
- (3) An estimate of any potential savings of State funds associated with expansion of the program.*

*If expansion of the program is recommended, a time line for expanding the program.*

## **Background**

Emergency Medical Service (EMS) agencies who have developed advanced training for their paramedics, partnerships with their Local Management Entity/Managed Care Organization (LME/MCO) and community based behavioral health crisis providers, and mutually agreed upon protocols are often able to successfully divert individuals in behavioral health crisis to alternatives other than local hospital emergency departments. This has been demonstrated in community paramedicine pilot programs funded by grants or local governments in Wake County for more than five years and in Onslow County for close to two years. Successful emergency department diversion offers an advantage to the individual who is directed to an alternative location for a specialty behavioral health crisis intervention. It offers an advantage to emergency departments who are increasingly overwhelmed with individuals in behavioral health crisis. It offers an advantage to the LME/MCO when intrusive and expensive higher end services are avoided and

care coordination is simplified as the individual arrives at an LME/MCO's contracted crisis provider. Relevant statutes do not prohibit a "treat and release" alternative or a "transport to alternative destination" choice of disposition. However, there has been no reimbursement mechanism for the EMS provider to be paid unless the call results in a trip to an emergency department, limiting opportunities for replication of this innovative model.

As part of the NC Department of Health and Human Services (DHHS) Crisis Solutions Initiative, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the NC Office of EMS (OEMS) are partnering on strategies to replicate and sustain this successful model of crisis intervention and diversion from unnecessary hospital emergency department visits for individuals in behavioral health crisis. In State Fiscal Year (SFY) 2015, DMH/DD/SAS began Phase I of a plan to expand the model, utilizing federal mental health block grant funds to solicit applications for awards of \$5,000 capacity building "mini-grants". The awards stimulated partnerships between EMS agencies, LME/MCOs, and crisis providers and covered some costs involved to get paramedics enrolled in LME/MCO sponsored Crisis Intervention Team Training (CIT) classes for advanced mental health and substance use disorder training in eleven counties. DMH/DD/SAS and OEMS also collaborated with the existing Wake and Onslow programs to draft a standardized clinical guidelines document and to study and select mechanisms that might be used to reimburse EMS agencies at a fair rate for the assessment and intervention service and a transport to an alternative destination. The attached document, Community Paramedicine Behavioral Health Crisis Response Pilot Site Requirements, fully describes the eligibility requirements for participation.

### **Current Status**

As a result of the funding appropriated with this legislation, Phase II of the "Community Paramedicine Behavioral Health Crisis Response" pilot is now underway. Twelve of the thirteen pilot sites have elected to participate (see Appendix A for the participation details). Each of those partnerships provided estimates of the numbers of individuals they could assess/treat on scene or transport/divert to Behavioral Health Urgent Care centers. Funding was allocated to the home LME/MCO to establish a contractual relationship with each participating EMS agency for per event service reimbursement. Additional federal block grant funding was made available to supplement any potential uncovered costs for the interested and eligible pilot sites. Requests from newly interested counties for the \$5,000 "mini-grants" have also been considered. Programs are in various stages of development. Even the existing partnerships had to evolve – formalizing relationships in order to begin actively billing for the crisis response and diversion services. Prerequisite local steps have been agreed upon as essential to successful future institutionalization of this model. In summary, these include:

- Community assessment, planning, identification of key stakeholders and partnership leaders, identification of alternative behavioral health crisis resources.
- Scheduling, coordination, and delivery of the advanced training in mental health and substance use for the individual paramedic practitioners.
- Development of clinical assessment tools and documentation that are regionally consistent across multiple agencies.
- Development of contracts between EMS agencies and LME/MCOs which will allow access to the service event reimbursement funding.
- Training and implementation on use of the statewide web based data collection tool that will assist in program evaluation.

Each of these steps requires significant investment of time and energy on the parts of each of three primary partners – LME/MCO, Behavioral Health Urgent Care providers, and EMS agencies. In addition, other key stakeholders such as hospitals, county managers and attorneys must be educated and invested in order to contribute to the success of the program.

Another lesson learned to date is that changes in any of the systems has the ability to interrupt or delay the implementation. For instance, Durham EMS had an established relationship with an alternative destination provider and some beginning experience with the diversion protocols. However, that provider's contract was not renewed. The LME/MCO solicited a new provider, resulting in the need for new contractual relationships and a temporary delay in initiation of the pilot. The DMH/DD/SAS and OEMS program managers maintain active communication with each of the pilot sites. DMH/DD/SAS has developed a web-based data collection tool and provided training to all sites in December 2015. Personalized technical assistance is available to all of the sites at any time.

It is very early to provide details of a concrete evaluation plan as required in Section 12F.8 (b). DMH/DD/SAS has reviewed the U.S. Department of Health and Human Services, Health Resources and Services Administration Office of Rural Health Policy's, Community Paramedicine Evaluation Tool, published in March 2012, with OEMS. Although the tool appears to be designed for a broader community paramedicine model, we do believe the structure of it will be useful to assist the pilots and future sites through the prerequisite steps outlined on the previous page. The Wake County program has in fact already completed its first self-assessment. One other site – in a more rural community – will be recruited to complete it before the final report on this legislation is due in November 2016. In addition to the prescribed evaluation tool, the data from the web-based collection tool will be analyzed for more information about client demographics, diagnoses, and clinical outcomes. DMH/DD/SAS is also working internally and with OEMS and the Division of Medical Assistance to analyze cost benefits and return on investment metrics for the report in November 2016.

In summary, the pilot project is progressing at a very satisfactory pace. It appears funds will be fully expended by the close of SFY 2016 and that additional dollars from federal block grant funds will be utilized to supplement the initial pilot sites which are making a later full start. Early data suggests 20% - 30% of individuals in behavioral health crisis can be successfully diverted from emergency departments to alternative crisis providers in communities with strong local leadership and the necessary resources in place. Further analysis of cost benefits associated with the clinical benefits and the benefits associated with reduced volume in the emergency departments is also needed.

#### APPENDIX A

LME/MCO & EMS COUNTY	Start date for contracted service event reimbursement	Projected Events for SFY2016	Funding allotted	Notes
Alliance/Durham	3/1/2016	70	\$ 14,770	Delayed due to change in community crisis provider
Alliance/Wake	7/1/2015	500	\$ 105,500	
Cardinal/Halifax	9/1/2016	20	\$ 4,220	
Cardinal/Orange	?		\$ -	Still working on community and contract protocols with LMEMCO leadership
CenterPoint/Forsyth	5/1/2016	100	\$ 21,100	Delayed in order to coordinate planning & assessment tools across CenterPoint counties
CenterPoint/Rockingham	5/1/2016	50	\$ 10,550	Delayed in order to coordinate planning & assessment tools across CenterPoint counties
CenterPoint/Stokes	5/1/2016	20	\$ 4,220	Delayed in order to coordinate planning & assessment tools across CenterPoint counties
Partners/Lincoln	7/1/2016	125	\$ 26,375	
Sandhills/Guilford	9/1/2016	20	\$ 4,220	
Smoky/McDowell	12/15/2016	20	\$ 4,220	
Trillium/Brunswick	?		\$ -	Still working on community and contract protocols with LMEMCO leadership
Trillium/Onslow	7/1/2016	210	\$ 44,310	
<b>ADDITIONAL LME/MCO &amp; EMS COUNTIES RECEIVING CAPACITY BUILDING MINI-GRANTS</b>				
Alliance/Johnston		0	\$ 5,000	
CenterPoint/Davie		0	\$ 5,000	
Smoky/Buncombe		0	\$ 5,000	

**Attachment: Community Paramedicine Behavioral Health Crisis  
Response Pilot Site Requirements**



## COMMUNITY PARAMEDICINE BEHAVIORAL HEALTH CRISIS RESPONSE

### Requirements for LME/MCOs and EMS Agencies participating in the Service Reimbursement Pilot Program – State Fiscal Year 2016

The North Carolina 2015 Appropriations Act, Session Law 2015-241, Section 12F.8.(a) includes a non-recurring state appropriation of \$225,000 for the Division of MH/DD/SAS to continue the department's efforts EMS agencies participating in the pilot program to divert behavioral health consumers from emergency departments. (See Appendix A at the end of this document for a copy of the legislative mandated language.) The legislation requires development of an evaluation plan, and two reports on the results – in June 2016 and November 2016.

In addition, DMH/DD/SAS has identified a sum of federal block grant dollars to supplement the state appropriation throughout the course of State Fiscal Year 2015 – 2016.

It is the intent of DMH/DD/SAS to offer a limited number of additional \$5,000 capacity building mini-grants, and to use the bulk of the available funds to begin service event reimbursement. Priority will be given to those 13 programs\* that are already actively diverting individuals from emergency departments to alternative behavioral health destinations and/or are in the development process for doing so; and that meet the following conditions of participation.

1. **3-WAY PARTNERSHIP.** Local partnerships must consist of the LME/MCO, the EMS agency, and at least one BH Urgent Care Center that is part of the LME/MCO's contracted provider network and that offers a diversionary option for individuals in behavioral health crisis. The three partners will be expected to have mutually developed policies/procedures/guidelines that meet standards with each of their respective oversight bodies. LME/MCOs and EMS agencies will be expected to establish a contracting relationship that allows for EMS agencies to be reimbursed via submission of invoices that include detailed patient level encounter data as described below. The LME/MCO will be responsible to assure the information in this document and in any future communications are communicated with the other partners.
2. **STANDARDS FOR AGENCIES AND INDIVIDUAL PARAMEDICS.** In addition to being credentialed as an emergency medical technician-paramedic, individual practitioners providing this service must be appropriately trained and certified in an LME/MCO approved crisis intervention training program. This will usually be a 32 – 40 hour community college sponsored Crisis Intervention Team training course coordinated by the LME/MCO. See Appendix B at the end of this document for the full *Definition, Guidelines and Standards for Pilot Site Implementation*.
3. **DATA COLLECTION.** DMH/DD/SAS has established a data collection tool that will capture patient level information that will meet the needs of the required state and legislative reporting, and function as a portion of the invoice. See Appendix C for the Community Paramedicine Behavioral Health Data Sheet. A web-based version is in final development at DMH/DD/SAS and a webinar training for using the automated system will be announced in the near future.

4. **RATE STRUCTURE.** Participating LME/MCOs and EMS agencies will be expected to follow the two-tiered “per event, no mileage” rate structure outlined here:
  - a. The Tier 1 rate has been set to be analogous to the average reimbursement for other BLS treat/no transport events. \$164.00/event will be paid for those events where EMS provides on-site assessment and intervention for an individual in crisis who does not need transport to an alternative destination for further stabilization.
  - b. The Tier 2 rate has been set to be analogous to the average reimbursement for other BLS non-emergency transport events. \$211.00/event will be paid for those events where EMS provides on-site assessment and intervention for an individual in crisis who requires transport to an alternative destination for further stabilization.
5. **AVAILABLE FUNDING and SPECIAL CONDITIONS.** At the time of this writing, DMH/DD/SAS cautiously anticipates being able to fully fund one year of service events for each participating agency. DMH/DD/SAS will allocate funds based upon the anticipated volume of events, as provided by the LME/MCO.

This is one-time funding associated with reporting requirements to assess return on investment factors so consideration can be given to future expansion of the program within other revenue streams (such as Medicaid). It is essential for participating programs to comply with requirements outlined in this document and the following conditions in order to gather and analyze the data.

  - a. Eligible partnerships will agree to maintain the BH Crisis Response service throughout the contract period even if/when available Federal/State dollars are exhausted. LME-MCOs may choose to utilize other funds to supplement the DMH/DD/SAS allocation.
  - b. Eligible partnerships will agree to continue reporting even if/when funds for reimbursement are exhausted before the end of the contract period.
  - c. Eligible partnerships understand that DMH/DD/SAS does not guarantee any funding in future years.

\*The priority programs include:

Alliance Behavioral Healthcare -- Wake EMS and Durham EMS.

Cardinal Innovations Healthcare Solutions -- Orange EMS, Halifax EMS, and Franklin EMS.

CenterPoint Human Services -- Forsyth EMS, Stokes EMS, and Rockingham EMS.

Partners Behavioral Health Management -- Lincoln EMS.

Sandhills Center - Guilford EMS.

Smoky Mountain LME/MCO – McDowell EMS.

Trillium Health Resources – Onslow EMS and Brunswick EMS.

Other programs may be considered based upon available funding.

DMH/DD/SAS contact for this pilot project:

Crystal Farrow, Crisis Solutions Initiative Project Manager

[Crystal.Farrow@dhhs.nc.gov](mailto:Crystal.Farrow@dhhs.nc.gov) or 919-715-1294



APPENDIX A

Excerpt from North Carolina General Assembly, Session Law 2015-241, Appropriations Act of 2015, Pages 167 - 168

“COMMUNITY PARAMEDIC MOBILE CRISIS MANAGEMENT PILOT PROGRAM

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- (4) An updated version of the evaluation plan required by subsection (b) of this section.
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- (7) If expansion of the program is recommended, a time line for expanding the program.”

**COMMUNITY PARAMEDICINE BEHAVIORAL HEALTH CRISIS RESPONSE**  
**Definition, Guidelines and Standards for Pilot Site Implementation**  
**NC DMH/DD/SAS**  
**November 2, 2015**

**Introduction and Background**

An Emergency Medical Service (EMS) agency who has developed advanced training for its paramedics, partnerships with their Local Management Entity/Managed Care Organization (LME/MCO) and community based behavioral health crisis providers, and mutually agreed upon protocols are often able to successfully divert individuals in behavioral health crisis to alternatives other than local hospital emergency departments. This has been demonstrated in pilot programs in North Carolina communities.

Successful emergency department diversion offers an advantage to the individual who is directed to an alternative location for a specialty behavioral health crisis intervention. It offers an advantage to emergency departments who are increasingly overwhelmed with individuals in behavioral health crisis. It offers an advantage to the LME/MCO when intrusive and expensive higher end services are avoided and care coordination is simplified as the individual arrives at an LME/MCO's contracted crisis provider.

Relevant statutes do not prohibit a "treat and release" alternative or a "transport to alternative destination" choice of disposition. However, there has been no mechanism – for publicly funded recipients -- for the EMS provider to be paid unless the call results in a trip to an emergency department, limiting opportunities for replication of this innovative model.

The NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the NC Office of EMS (OEMS) are partnering on strategies to replicate and sustain this successful model of crisis intervention and diversion from unnecessary hospital emergency departments visits for individuals in behavioral health crisis.

This document outlines requirements for eligible EMS agencies to receive reimbursement of a Community Paramedicine Behavioral Health Crisis Response service event through a contract with an LME/MCO using pilot funding available in State Fiscal Year 2015 – 2016 from DMH/DD/SAS.

**Service Definition and Required Components**

Community Paramedicine Behavioral Health Crisis Response provides triage, assessment of immediate behavioral health crisis needs, on-site intervention, and referral to an LME/MCO's continuum of crisis intervention services and supports when there are not physical health needs that require further assessment or intervention in a general hospital emergency department. The assessment will include evaluation of an individual's medical stability, mental status, and risk of harm to self or others. On-site intervention may include verbal de-escalation and supportive interviewing to identify the individual's existing supports (including crisis plans, supportive family/friends, or other involved professionals, etc). Medication may be used per local protocol. Referrals will be based upon the assessment and the pathways to access care as mutually agreed upon within the contract between an LME/MCO and an EMS

department. When needed, transportation to a non-emergency department behavioral health alternative site such as a Behavioral Health Urgent Care Center —either by ambulance or another specially designated vehicle—will be included.

### **Provider Organization Requirements**

Community Paramedicine Behavioral Health Crisis Response must be delivered by an EMS Provider agency that holds a valid EMS license as issued by the NC Department of Health and Human Services/OEMS. The agency must meet all requirements established within NC General Statute 131E-155. The agency must meet all requirements established within NC Administrative Code 10A NCAC 13P.

The service must be delivered by practitioners within the licensed provider agency who are credentialed at the level of “emergency medical technician – paramedic” as defined in NCGS 131E-155 and who have completed the additional requisite staff training described below.

### **Requisite Staff Training**

In addition to being credentialed as an emergency medical technician-paramedic, individual practitioners providing this service must be appropriately trained and certified in an LME/MCO approved crisis intervention training program. This will most often be via a 32 – 40 hour community college sponsored Crisis Intervention Team training course that is designed and coordinated by the LME/MCO to train EMS, law enforcement, and other first responders. In-service or skills-building training or training as recommended by joint EMS-LME/MCO quality improvement processes may also be required per contract between the organizations.

### **Service Type/Setting**

Community Paramedicine Behavioral Health Crisis Response occurs only in the context of a usual EMS response call. This is not a service that is intended to be dispatched by any other means. Once the EMS provider is on the scene and all protocols have been followed to determine there is no indication of a need for further assessment or intervention in a hospital emergency department, and that the call/response is for a behavioral health crisis, this service may begin.

### **Program Requirements**

Community Paramedicine Behavioral Health Crisis Response must be available to both adults and children in behavioral health crisis. The service may be delivered by one or more individual paramedic staff.

### **Entrance Criteria**

Individuals are eligible for this service when the following criteria are met:

- A. Individual, or someone on the individual’s behalf, has called 911 and an EMS provider has responded to the scene of the call.

And

- B. The EMS provider has followed established protocols to determine the appropriate response for the individual's need is a behavioral health assessment or treatment rather than transport to a hospital emergency department for an intervention for a physical health complaint.

No prior authorization is required for this service.

### **Entrance Process**

The individual voluntarily consents to the recommended alternative assessment, treatment, and/or destination.

### **Continued Stay Criteria**

N/A. This is a short-term assessment, intervention, and immediate stabilization service.

### **Discharge Criteria**

The individual's behavioral health crisis has been stabilized, his/her need for ongoing supports and/or access to treatment resources has been assessed. Referrals, "warm" hand-offs, and transportation as needed have been made to assure the individual is successfully linked to the support or service needed to resolve the crisis.

### **Documentation Expectations**

The Community Paramedic will be expected to document each service event and to provide that documentation to the LME/MCO in an agreed upon format. When the call results in transport to an alternative destination the Community Paramedic will complete and deliver an individual service note, a copy of which will be included in the individual's medical record at the behavioral health provider.

The EMS agency will be expected to provide data about each service event – that will be used in aggregate format to evaluate the results of this pilot service -- to the LME/MCO and/or DMH/DD/SAS in a prescribed format.

### **Expected outcomes**

- The individual's crisis will be rapidly triaged to assess the severity and to provide immediate focused crisis intervention services mobilized based on the type and urgency. The immediate interventions will range from a "treat and release" to "transport to alternative behavioral health destination".
- The individual and his/her immediate support system will gain understanding of earlier intervention strategies and applicable community resources for behavioral health crisis episodes.

### **Service Limitations**

Community Paramedicine Behavioral Health Crisis Response is limited to one event per 24 hours.

**Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of this Service**

Partners in this process including the NC DMH/DD/SAS, the LME/MCO, the EMS Organization, and the Behavioral Health Crisis Service Provider(s) will monitor data related to:

- Changes in the number of ED visits for primary mh/sa crisis episodes
- Changes in the utilization of alternative behavioral health resources
- Changes in the utilization of EMS call to individuals in behavioral health crisis

And,

Will engage in “high risk” planning conferences with the EMS provider and other community resources for individuals who are high-end users of this service.

## APPENDIX C

### Community Paramedicine Behavioral Health Data Submission

Data submission steps are as follows:

1. The EMS Program shall utilize either the attached Community Paramedicine Behavioral Health Data Sheet to collect patient level data on persons diverted from EDs under this program, or their own method that is inclusive of all data elements as indicated on the data sheet.
2. EMS Program shall enter the required data into the web-based system provided by DMHDDSAS. It may be entered throughout the month, or as often as makes sense locally. One person (with a designated backup) from each Program will have a login (that cannot be shared) to the web form, and will set up a brief profile that includes the local list of Alternative Destinations.
3. Patient name and ID are not entered into the web form, so that the submitted data does not include Private Health Information. The Program should write the web-generated unique number on their source information, to assist with data matching should corrections be necessary.
4. At the end of the month, the Program can review the entries they made that month, and make any corrections or deletions if necessary.
5. Once it's correct, the Program submits that month's entries, which stamps the data with a submit date and locks the information to prevent further changes. The month's entries are due by the 10<sup>th</sup> of the subsequent month (weekend due dates roll to the following Monday).
6. The Program can then export their data for the month to Excel, which should be printed and attached to the invoice submitted to the LME/MCO, ensuring the evaluation data is entered for each incident that is reimbursed. The Program and LME/MCO can also use the Excel output to do their own local analysis.

## Community Paramedicine Behavioral Health Data Sheet

Instructions: Complete this form on all behavioral health patients treated/left on the scene or transported to an approved alternative location, or transported to an ED. Enter into DMHDDSAS website by the 10th day of the month for incidents that occurred during the previous month.

<b>Patient Name (or ID):</b> _____ (not entered in web)      Web System ID: _____ _____ <b>Incident Number:</b> _____ (not entered in web)	
<div style="text-align: center; background-color: black; color: white; padding: 2px;"><b>SECTION A</b></div> <p><b>ALL FIELDS IN THIS SECTION MANDATORY:</b>          Address City: _____          Patient DOB (MM/DD/YYYY): _____          Patient Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female          Payer reported by Patient (select one):  <input type="checkbox"/> Medicaid  <input type="checkbox"/> Medicare  <input type="checkbox"/> Medicaid/ Medicare  <input type="checkbox"/> VA/CHAMPUS  <input type="checkbox"/> Commercial Insurance  <input type="checkbox"/> Indigent/State Funded  <input type="checkbox"/> Self-Pay          Behavioral Health Disability based on Patient's presentation (select one):  <input type="checkbox"/> Mental Illness (MH)  <input type="checkbox"/> Substance Used Disorder (SUD)  <input type="checkbox"/> Intellectual/Developmental Disorder (IDD)  <input type="checkbox"/> MH/SUD  <input type="checkbox"/> MH/IDD  <input type="checkbox"/> SUD/IDD  <input type="checkbox"/> MH/SUD/IDD          On-Scene Date (MM/DD/YYYY): _____          On-Scene Time (military): _____  <b>CHOOSE ONE:</b>  <input type="checkbox"/> Treat No Transport (<i>complete Section B</i>)  <input type="checkbox"/> Transported to Alternative Location</p>	<div style="text-align: center; background-color: black; color: white; padding: 2px;"><b>SECTION C</b></div> <p><b>IF TRANSPORTED TO ALTERNATIVE LOCATION, COMPLETE ALL FIELDS IN THIS SECTION:</b>          Patient Transfer Date (MM/DD/YYYY): _____          Patient Transfer Time (military): _____          Mode of Transportation:  <input type="checkbox"/> Ambulance  <input type="checkbox"/> Law Enforcement          Alternative Destination Facility Name: _____          _____          Alt. Dest. Arrival Date (MM/DD/YYYY): _____          Alt. Dest. Arrival Time (military): _____  <b><u>Based On Follow-Up With Facility:</u></b>          Alternative Destination D/C Date: _____          Alternative Destination D/C Time: _____          Final Disposition (select one):  <input type="checkbox"/> <b>Transfer to a Hospital ED (complete item below)</b>  <input type="checkbox"/> Transfer to a Tier IV BH Urgent Care Ctr  <input type="checkbox"/> Outpatient/Community MHDDSA Svcs or Supports  <input type="checkbox"/> Facility Based Crisis</p>

<p># of Miles: _____ (complete Section C)</p> <p><input type="checkbox"/> Transported to ED</p> <p># of Miles: _____ (End of Survey)</p> <hr/> <p style="text-align: center;"><b>SECTION B</b></p> <p><b>If Treat No Transport:</b></p> <p>Left Scene Date (MM/DD/YYYY): _____</p> <p>Left Scene Time (military): _____</p> <p>Was BH Provider called to scene? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, name of provider care was transferred to:</p> <hr/>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Community Psychiatric Inpatient service</li> <li><input type="checkbox"/> Jail/Detention Center</li> <li><input type="checkbox"/> State psychiatric hospital</li> <li><input type="checkbox"/> State ADATC</li> <li><input type="checkbox"/> VA Hospital</li> <li><input type="checkbox"/> Psychiatric Residential Treatment Facility (PRTF)</li> <li><input type="checkbox"/> Left AMA/Refused Services</li> <li><input type="checkbox"/> Non-Hospital Detox</li> <li><input type="checkbox"/> Died</li> <li><input type="checkbox"/> Home pending LOC availability</li> </ul> <p><b>If sent to ED, what reason? (select one)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Medical Emergency</li> <li><input type="checkbox"/> Psychiatric Acuity</li> <li><input type="checkbox"/> Medical Clearance</li> <li><input type="checkbox"/> Tier III Closing Time</li> <li><input type="checkbox"/> Center Capacity</li> </ul>
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