# Final Report on the Community Paramedic Mobile Crisis Management Pilot Program

## Session Law 2015-241, Section 12F.8.(d)

**Report to the**

**Joint Legislative Oversight Committee on Health and Human Services**

**and**

**Fiscal Research Division**

**By**

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

**November 1, 2016**

## Introduction

This final report is submitted in fulfillment of requirements specified in Session Law 2015-241 Section 12F.8 (d):

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

## Executive Summary

The purpose of the Community Paramedic Mobile Crisis Management Pilot Program was to develop and evaluate a program designed to use specially trained Emergency Medical Services (EMS) staff to intervene with patients experiencing behavioral health crises, and provide incentives for the participating EMS to either treat on-scene or route those patients not needing medical treatment to lower cost alternatives to hospital emergency departments (EDs). Funding was provided to twelve EMS agencies that collaborated with Local Management Entity/Managed Care Organizations (LME/MCOs) and local providers to implement this program model. The results indicated that:

- Approximately a third (32%) of patients for whom EMS services are delivered could be appropriately treated on scene or diverted to an alternative crisis receiving facility other than an ED.
- Start up for these pilot programs took longer than expected, resulting in few service events being delivered, other than by programs that were already implementing these services prior to State Fiscal Year (FY) 2015-2016.
- The most successful pilot programs had strong behavioral health crisis intervention infrastructures, particularly 24/7 facility-based crisis centers, that were able to receive consumers for crisis care.
- Although preliminary evidence suggests these programs likely had significant cost benefits, the slow start to these programs resulted in an insufficient data upon which to base firm conclusions about their cost effectiveness.

The following detailed report provides further background, program description, and information about the progress of the community paramedic mobile crisis management pilot programs.

## Background

Emergency Medical Service (EMS) agencies that 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 (EDs). 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 ED 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 a LME/MCO's contracted crisis provider.

Applicable 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 ED, limiting opportunities for replication of this innovative model.

As part of the Department of Health and Human Services (DHHS) Crisis Solutions Initiative – a strategy that focuses on identifying and implementing the best known strategies for crisis care – the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the NC Office of EMS (OEMS) partnered on ways to fund, replicate, and sustain this successful model of crisis intervention and diversion from unnecessary hospital ED visits for individuals in behavioral health crisis. This initiative was rolled out in two phases.

**Phase I**

The first phase involved initiating the groundwork necessary to expand the Behavioral Health Paramedic model. Using federal mental health block grant funds to solicit applications for awards of $5,000 capacity building "mini-grants," these 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 (CIT) classes for advanced mental health and substance use disorder training in eleven counties. In addition, requests from newly interested counties for the $5,000 "mini-grants" were later considered and awarded to EMS agencies in Johnston, Davie, and Buncombe counties. DMH/DD/SAS and OEMS also collaborated with the existing Wake and Onslow programs to draft clinical guidelines and to study and select mechanisms to be used to reimburse EMS agencies at a fair rate for the assessment and intervention service and transport to an alternative destination, when necessary. The Community Paramedicine Behavioral Health Crisis Response Pilot Site Requirements, fully describes the eligibility requirements for participation [see Attachment A].

**Phase II**

Thanks to the funding appropriated with the authorizing legislation, Phase II of the "Community Paramedicine Behavioral Health Crisis Response" pilot was able to begin. Additional federal block grant funding was made available to supplement any potential uncovered costs for the interested and eligible pilot sites.

Twelve of thirteen pilot sites elected to participate in phase two (Brunswick EMS elected to withdraw from the pilot program).[1] Each of those partnerships provided estimates of the number

[1] This decision was made by the Brunswick EMS director following the closure of several sites in Brunswick County that were going to be used as receiving facilities for persons with behavioral health crises.

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. EMS agencies were to be reimbursed at two different levels or "tiers," depending upon whether or not the EMS agency provided treatment on scene, or transported the patient to an alternative crisis response facility. The "treat but no transport events" were reimbursed $164 per event, and the "treat and transport" events were reimbursed $211 per event.

**Community Paramedicine Evaluation Tool**

DMH/DD/SAS staff reviewed with OEMS the Community Paramedicine Evaluation Tool published in March 2012 by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. Although the tool appears to be designed for a broader community paramedicine model, we believe its structure can be useful to assist the pilots and future sites. The tool is designed as a process evaluation instrument, to be completed as a self-evaluation by the program, in order to assist in the development of a high quality paramedicine program. It does not, however, address the specific goals of this pilot program, i.e., the diversion of behavioral health consumers to either be treated on the scene or transported to a behavioral health specialty service, instead of hospital EDs. These objectives and the cost benefit analysis will be assessed with the data collected directly from the pilot sites and LME/MCOs. The Wake County program has already completed their first self-assessment utilizing the Community Paramedicine Evaluation Tool. Other locations will be encouraged to utilize the tool for self-assessment and improvement.

**Progress on Implementation**

Programs progressed at different rates, as the various pilot sites experienced different challenges. The programs in Wake and Onslow counties were more firmly established through local funding prior to this pilot project, but even these existing partnerships had to evolve – formalizing relationships in order to begin actively billing for the crisis response and diversion services. Prerequisite local steps were determined to be essential to successful future institutionalization of this model. In summary, these included:

- 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 were regionally consistent across multiple agencies
- Development of contracts between EMS agencies and LME/MCOs necessary to allow access to the service event reimbursement funding

- Training and implementation on use of the statewide web-based data collection tool to assist in program evaluation

Each of these steps required 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 hospital executives, county managers and attorneys, needed to be educated about the program in order to contribute to its success.

Much time was needed to negotiate protocols and procedures between the involved partners. Also, changes in any one of the systems could interrupt or delay the implementation. For example, 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 then solicited a new provider, resulting in the need for new contractual relationships and a temporary delay in initiation of the pilot. In addition, the need to provide CIT training to paramedics resulted in delays in some areas. As a result of these factors;

- Four of the twelve original pilot EMS agencies (in Franklin, Orange, Rockingham, and Stokes counties), provided no reimbursable behavioral health paramedic service events in FY 2015-2016.[2]
- Five of the original EMS agencies (in Durham, Forsyth, Guilford, Halifax, and McDowell counties) provided only a very limited number of behavioral health service events.
- Only the three original EMS agencies (Lincoln, Onslow, and Wake) that were already providing behavioral health service events through local funding prior to the start of this pilot program were able to fully implement phase two.

The chart on the next page illustrates the numbers of service events delivered by the eight EMS agencies with community behavioral health paramedics, classified by four different outcomes: (1) service events that resulted in the crisis being resolved "on scene," (2) events during which the individual was transported to an alternative location to the ED, (3) events in which individual was transported to an ED, and (4) those events resulting in the individual being transported to a psychiatric hospital. The final three columns of this chart indicate the costs per EMS agency associated with those service events that involved no transport or transport to an alternative to the ED.

[2] The three EMS agencies (in Davie, Johnston, and Buncombe counties) that received start-up funds in May 2016 were not expected to bill for any reimbursable service events in FY 2015-2016.

| Fiscal Year | FY16 |
|---|---|

**Transportation Counts**

| EMS Program | No Transport (Treat on Scene) | Transported to Alternative Location | Transported to ED | Transported to Psychiatric Hospital | Grand Total | For Svc Events Reported with FY16 Dates: No Transport Svc Value @$164 | Alt Loc Svc Value @$211 | Total Value |
|---|---|---|---|---|---|---|---|---|
| Durham EMS | 41 | 9 | 124 | | 174 | $ 6,724 | $ 1,899 | $ 8,623 |
| Forsyth EMS | 2 | | 4 | | 6 | $ 328 | $ - | $ 328 |
| Guilford EMS | | 6 | 6 | 7 | 19 | $ - | $ 1,266 | $ 1,266 |
| Halifax EMS | 3 | 1 | 422 | | 426 | $ 492 | $ 211 | $ 703 |
| Lincoln EMS | 52 | 59 | 263 | | 374 | $ 8,528 | $ 12,449 | $ 20,977 |
| McDowell EMS | 17 | 5 | | | 22 | $ 2,788 | $ 1,055 | $ 3,843 |
| Onslow EMS | 79 | 85 | 348 | | 512 | $ 12,956 | $ 17,935 | $ 30,891 |
| Wake EMS | 272 | 200 | 930 | 75 | 1,477 | $ 44,608 | $ 42,200 | $ 86,808 |
| **Grand Total** | **466** | **365** | **2,097** | **82** | **3,010** | **$ 76,424** | **$ 77,015** | **$ 153,439** |

## Program Evaluation

The goals of this program are:

1. To divert individuals in behavioral health crisis to specialized behavioral health services, rather than a hospital ED;

2. To ensure individuals in behavioral health crisis, once fully evaluated, are referred to the least intrusive care that meets their treatment needs, without being in violation of the Emergency Medical Treatment and Labor Act (EMTALA) rules on hospitals that restrict involuntary commitment (IVC) transfers to any facility but those providing the highest and costliest level of care (inpatient); and

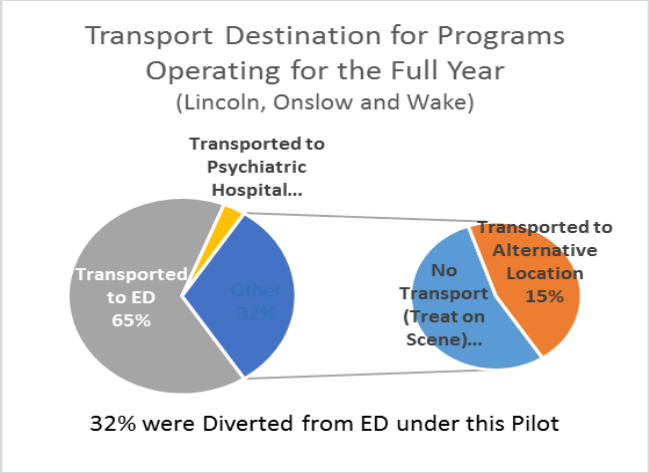
3. By reducing ED usage and inpatient care, to reduce the cost of behavioral health crises.

The evaluation plan for this pilot is to assess the success of the programs in achieving these goals. Given that several of the sites were slow to get started, the information available thus far is preliminary.

During FY16, data was collected from eight pilot sites, for each event where the patient was evaluated by trained EMS staff to have a mental health, substance use, or intellectual/developmental disability. Three programs reported data for the full year, and the other five reported data for one to seven months.

Diversion was considered successful if the individual in behavioral health crisis was transported to an alternative location instead of the hospital ED, or was treated at the scene without transportation. For the three programs that were functioning for the full year, 32% of patients were transported to an alternative location or treated at the scene. Including the partial year programs, 27% of patients were transported to an alternative location or treated at the scene. Of the individuals transported to an alternative location, 48% were referred to a lower level of care (e.g.,

outpatient, facility-based crisis or detox) and 9% were subsequently transferred from the alternative location to an ED.




The chart below shows the alternative sites to which patients were transported, and the numbers of patients the pilot EMS programs transported to those sites.

**Count of Persons Transported to Alternative Sites**

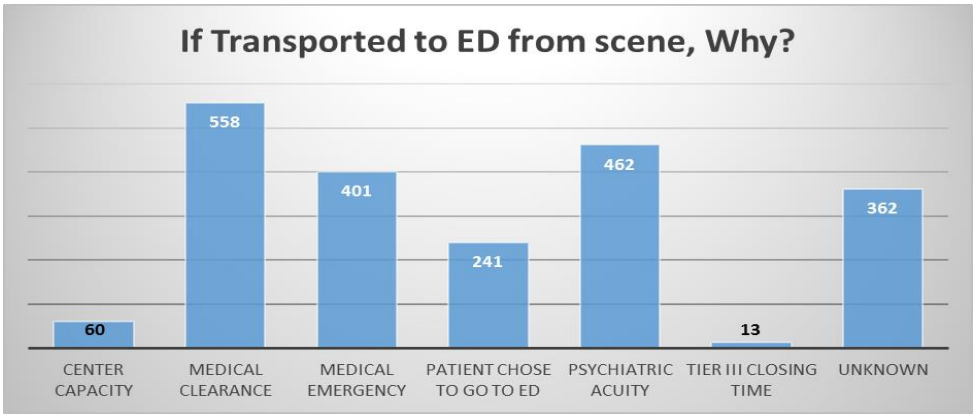
| EMS Program | Destination Facility | Count |
|---|---|---|
| Durham EMS | Durham Center Access | 8 |
| | Recovery Response Center | 1 |
| Guilford EMS | Monarch-Bellemeade Center | 6 |
| Halifax EMS | RHA | 1 |
| Lincoln EMS | Crisis Detox | 6 |
| | Lincoln Wellness Center | 36 |
| | Phoenix | 17 |
| McDowell EMS | RHA Walk In Clinic | 5 |
| Onslow EMS | RHA | 84 |
| | Missing | 1 |
| Wake EMS | Healing Transitions | 31 |
| | Wakebrooke | 169 |
| **Grand Total** | | **365** |

A small percentage (7%) of patients transported to an alternative site subsequently required transportation to an ED. Of the 25 individuals transferred from the alternative site to an ED, 17 were transferred for treatment of a medical emergency, four for psychiatric acuity, two for medical clearance, and one at the individual's request (data was missing for one individual). All of the 25 transports from alternative sites to an ED occurred in either Wake or Lincoln counties. These results are displayed in the table on the next page.

## If Transported to ED from Altern. Destination, Why?

| EMS Program | Medical Clearance | Medical Emergency | Patient Chose to Go to ED | Psychiatric Acuity | Unknown | Grand Total |
|---|---|---|---|---|---|---|
| Lincoln EMS | 2 | 1 | 1 | 3 | 1 | 8 |
| Wake EMS | | 16 | | 1 | | 17 |
| **Grand Total** | **2** | **17** | **1** | **4** | **1** | **25** |

As previously noted, about 65% of patients were still transported directly to the ED from the scene, and were not able to be de-escalated on scene or diverted to an alternative location. The reasons for their transportation from the scene to an ED were as follows:




The reasons for transportation to an ED rather than to an alternative location varied across EMS agencies. In Durham, the primary reason for transport of behavioral health patients to the ED was "medical emergency." However, the primary reason for transport to the ED in Halifax county was "psychiatric acuity." In Wake County, patients transported from on scene to the ED were most often taken to the ED for medical clearance. Differences in reasons for transport from on scene to the ED may reflect differences in resources and services between counties, or differences in policies of the EMS providers, or both. Reasons provided by the eight participating EMS programs are displayed in the table below:

## If Transported to ED from scene, Why?

| EMS Program | Center Capacity | Medical Clearance | Medical Emergency | Patient Chose to Go to ED | Psychiatric Acuity | Tier III Closing Time | Unknown | Grand Total |
|---|---|---|---|---|---|---|---|---|
| Durham EMS | 1 | 31 | 71 | 4 | 17 | | | 124 |
| Forsyth EMS | | | 1 | 1 | 2 | | | 4 |
| Guilford EMS | 5 | | | 1 | | | | 6 |
| Halifax EMS | 1 | 29 | 31 | 1 | 359 | 1 | | 422 |
| Lincoln EMS | 1 | 35 | 83 | 113 | 19 | 12 | | 263 |
| Onslow EMS | | 1 | 4 | 3 | 30 | | 310 | 348 |
| Wake EMS | 52 | 462 | 211 | 118 | 35 | | 52 | 930 |
| **Grand Total** | **60** | **558** | **401** | **241** | **462** | **13** | **362** | **2097** |

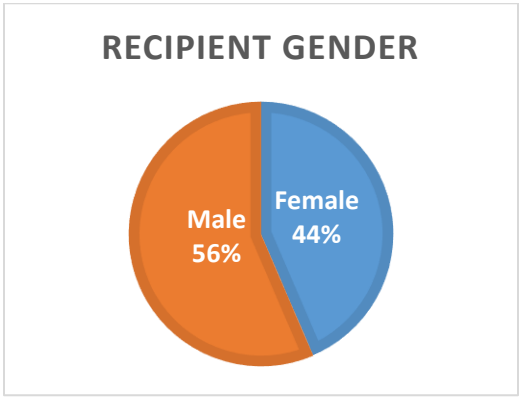
One indicator of success of diversion to these alternative sites is the extent to which patients were able to be diverted to a lower level of care following their discharge from an alternative site. Almost half (48%) of those for whom data about final disposition was available were able to be diverted to a lower level of care.[3]

**Final Disposition Upon Leaving Alternative Destination**

| | 48% Diverted to Lower Level of Care | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EMS Program | Outpatient/ Community MHDDSA Svcs or Supports | Facility Based Crisis | Non-Hospital Detox | Home pending LOC availability | Transfer to a Hospital ED | Community Psychiatric Inpatient service | Jail / Detention Center | Psychiatric Residential Treatment Facility | State Psychiatric Hospital | VA Hospital | Left AMA / Refused Services | Transfer to a Tier IV BH Urgent Care Ctr | Grand Total |
| Durham EMS | 3 | 1 | | | | 2 | | | | | 3 | | 9 |
| Halifax EMS | 1 | | | | | | | | | | | | 1 |
| Lincoln EMS | 10 | 25 | | 3 | 8 | 1 | | | | | 8 | | 55 |
| McDowell EMS | 4 | | | | | | | | | | 1 | | 5 |
| Onslow EMS | | | | | | | | | | | | 2 | 2 |
| Wake EMS | 28 | 30 | 28 | 5 | 17 | 73 | 1 | 2 | 4 | 1 | 8 | | 197 |
| **Grand Total** | **46** | **56** | **28** | **8** | **25** | **76** | **1** | **2** | **4** | **1** | **20** | **2** | **269** |
| **Percent of Total** | **17%** | **21%** | **10%** | **3%** | **9%** | **28%** | **0%** | **1%** | **1%** | **0%** | **7%** | **1%** | **100%** |

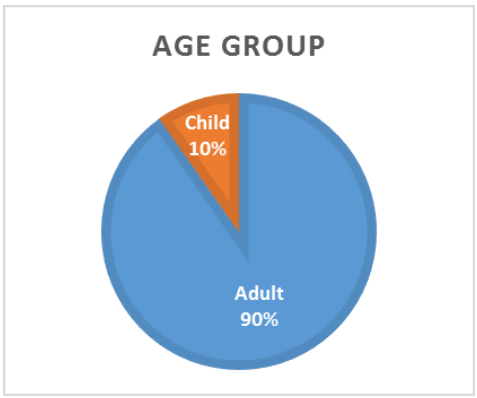
## Demographics for Patients Served

Limited demographic information was collected on patients served through these pilot programs. Data on gender of patients was collected, and indicated that a higher proportion of males than females were served through the community behavioral health paramedic program.




In addition, many more adults than children were served through these programs (see chart below).

[3] Data on final disposition was unavailable for 96 individuals or 26% of those transported to alternative destinations other than the ED.




Disabilities of patients served who were diverted from the ED, either through on-site interventions or transport to alternative crisis settings, are displayed below:

**Disability of Persons Served who were Diverted from the ED**

| EMS Program | Mental Illness (MH) | Substance Use Disorder (SUD) | MH/SUD | Intellectual / Developmental Disability (IDD) | MH/IDD | Grand Total |
|---|---|---|---|---|---|---|
| Durham EMS | 38 | 8 | 4 | | | 50 |
| Forsyth EMS | 1 | | | | 1 | 2 |
| Guilford EMS | 5 | | 1 | | | 6 |
| Halifax EMS | 4 | | | | | 4 |
| Lincoln EMS | 77 | 10 | 20 | 4 | | 111 |
| McDowell EMS | 16 | 3 | 2 | | 1 | 22 |
| Onslow EMS | 130 | 19 | 15 | | | 164 |
| Wake EMS | 245 | 163 | 60 | 1 | 3 | 472 |
| **Grand Total** | **516** | **203** | **102** | **5** | **5** | **831** |
| **% of Total** | **62%** | **24%** | **12%** | **1%** | **1%** | **100%** |

As expected, the majority of individuals (62%) who were diverted from the ED had primary diagnoses of mental illness. Approximately 24% had primary substance use disorders, while about 12% had co-occurring mental illness and substance use disorders.

## Cost – Benefit Analysis

Given the relatively low cost of crisis intervention services provided at an alternative site relative to providing these same services in the ED, it seems very likely that significant savings could be realized through the community behavioral health paramedics program. Indeed, individual EMS agencies have reported significant cost savings due to this program. However, insufficient information was available at the time of this report to conduct a valid cost – benefit analysis. The Office of Emergency Management Services (OEMS) is continuing to work with the Division of

Medical Assistance (DMA) and with independent actuaries to gather information that will enable a valid cost – benefit analysis of this program in the future.

Recommendations regarding expansion of this program should depend upon the results of the cost – benefit analysis that is currently underway. It is clear, however, that a plan to expand of this program - if that is recommended - will need to consider the infrastructure available to support the program, as well as the time it has taken our pilot programs to negotiate agreements, develop protocols, and provide CIT training to EMS staff / paramedics. The pilot sites that have achieved full implementation have available to them 24/7 facilities to which EMS can transport consumers as alternatives to the ED.[4] Experience suggests that expansion of this program would likely be most successful in those counties that similarly have 24/7 crisis facilities. The experience gained from this pilot program suggests that a time frame for full implementation, even in locations where sufficient infrastructure exists, can be expected to take up to a year.

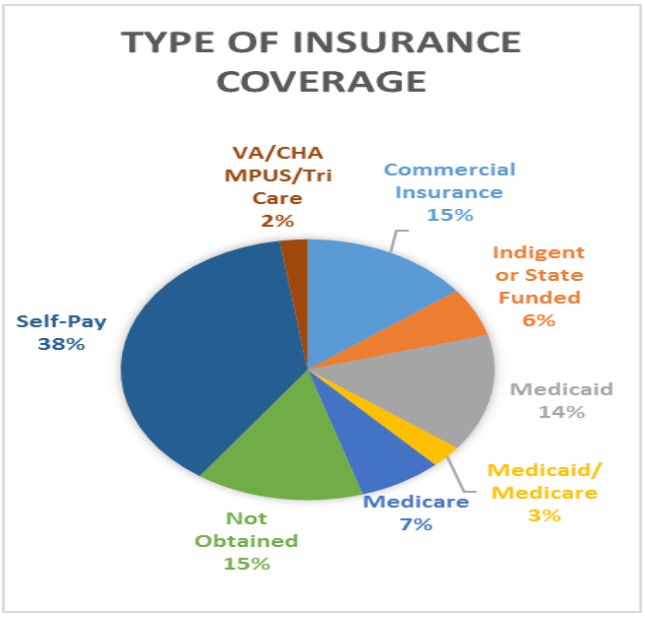
A valid cost-benefit analysis would need to consider payer source for these service events. The chart below shows the self-reported payer source for behavioral health paramedic services provided by each of the EMS agencies.

**Self-Reported Insurance Coverage, for Persons Not Transported and Transported to Alternative Sites**

| EMS Program | Commercial Insurance | Indigent or State Funded | Medicaid | Medicaid/ Medicare | Medicare | Not Obtained | Self-Pay | VA/CHAMPUS/TriCare | Grand Total |
|---|---|---|---|---|---|---|---|---|---|
| Durham EMS | 18 | 6 | 6 | | 1 | | 19 | | 50 |
| Forsyth EMS | | | 1 | | | | 1 | | 2 |
| Guilford EMS | | 1 | 1 | | 3 | | 1 | | 6 |
| Halifax EMS | 1 | | | 1 | 1 | | 1 | | 4 |
| Lincoln EMS | 7 | 2 | 20 | 10 | 4 | | 68 | | 111 |
| McDowell EMS | 1 | | 6 | 1 | 4 | | 8 | 2 | 22 |
| Onslow EMS | 9 | | 31 | 4 | 9 | | 95 | 16 | 164 |
| Wake EMS | 86 | 41 | 56 | 7 | 38 | 121 | 121 | 2 | 472 |
| **Grand Total** | **122** | **50** | **121** | **23** | **60** | **121** | **314** | **20** | **831** |

The proportion of payment from each payer source for all EMS agencies aggregated together is presented in the chart on the next page.

[4] Wake and Durham counties have 24/7 facility-based crisis centers, and Lincoln County's EMS is able to access a local crisis facility – the Lincoln Wellness Center – from 8:00am until midnight, after which EMS can transport to a 24/7 facility-based crisis center in a neighboring county.




**Summary and Conclusions**

The community behavioral health paramedicine program was established to help assure that people in crisis receive needed care in the most appropriate and least intrusive setting, while alleviating costs of behavioral health interventions for people in crisis in hospital EDs. It appears that only a few of the twelve EMS pilot programs, and only those that were already being implemented through local funds prior to this pilot program (Wake, Onslow, and Lincoln EMS) were able to reach full implementation. Four of the twelve EMS agencies (in Durham, Forsyth, Halifax, and McDowell counties) provided behavioral health interventions that included on-site resolution or transport to an alternative to an ED, but only in limited numbers. Five of the original twelve pilot programs did not provide any behavioral health service events.

Due to delays in implementation, all of the funds for this program were not expended by the close of SFY2016, and $159,378 in funding was carried over to FY 2017. These included $60,000 in additional dollars from federal block grant funds utilized to supplement the pilot sites that made a later start.

Further analysis of the cost benefit of these programs will be performed by OEMS in collaboration with the Division of Medical Assistance.

Attachment A

**COMMUNITY PARAMEDICINE BEHAVIORAL HEALTH CRISIS RESPONSE**

**Requirements for LME/MCOs and EMS Agencies participating in the Service Reimbursement Pilot Program - SFY16**

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 A 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 B 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.

APPENDIX A

**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 SFY 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/Office of Emergency Medical Services. 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 callc 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 B

Community Paramedicine BH 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 10th 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.

**Patient Name** (or ID): _____ (not entered in web) Web System ID:

_____

Incident Number: _____ (not entered in web)

**SECTION A**

**ALL FIELDS IN THIS SECTION MANDATORY:**

Address City: _____

Patient DOB (MM/DD/YYYY): _____

Patient Gender: [_] Male [_] Female

Payer reported by Patient (select one):

- Medicaid
- Medicare
- Medicaid/ Medicare
- VA/CHAMPUS
- Commercial Insurance
- Indigent/State Funded
- Self-Pay

Behavioral Health Disability based on Patient's presentation (select one):

- Mental Illness (MH)
- Substance Used Disorder (SUD)
- Intellectual/Developmental Disorder (IDD)
- MH/SUD
- MH/IDD
- SUD/IDD
- MH/SUD/IDD

**SECTION C**

**IF TRANSPORTED TO ALTERNATIVE LOCATION, COMPLETE ALL FIELDS IN THIS SECTION:**

Patient Transfer Date (MM/DD/YYYY): _____

Patient Transfer Time (military): _____

Mode of Transportation:

[_] Ambulance

[_] Law Enforcement

Alternative Destination Facility Name:

_____

Alt. Dest. Arrival Date (MM/DD/YYYY): _____

Alt. Dest. Arrival Time (military): _____

**Based On Follow-Up With Facility:**

Alternative Destination D/C Date: _____

On-Scene Date (MM/DD/YYYY): _____

On-Scene Time (military): _____

**CHOOSE ONE:**

[__] Treat No Transport *(complete Section B)*

[__] Transported to Alternative Location

# of Miles: _____ *(complete Section C)*

[__] Transported to ED

# of Miles: _____ *(End of Survey)*

_____

**SECTION B**

**If Treat No Transport:**

Left Scene Date (MM/DD/YYYY): _____

Left Scene Time (military): _____

Was BH Provider called to scene? [_] Yes [_] No

If yes, name of provider care was transferred to:

_____

Alternative Destination D/C Time:

_____

Final Disposition (select one):

- **Transfer to a Hospital ED (complete item below)**
- Transfer to a Tier IV BH Urgent Care Ctr
- Outpatient/Community MHDDSA Svcs or Supports
- Facility Based Crisis
- Community Psychiatric Inpatient service
- Jail/Detention Center
- State psychiatric hospital
- State ADATC
- VA Hospital
- Psychiatric Residential Treatment Facility (PRTF)
- Left AMA/Refused Services
- Non-Hospital Detox
- Died
- Home pending LOC availability

**If sent to ED**, what reason? (select one)

- Medical Emergency
- Psychiatric Acuity
- Medical Clearance
- Tier III Closing Time
- Center Capacity