



EMS BEHAVIORAL HEALTH REPORT

**An Examination of the Challenges of Transporting
Behavioral Health Patients in Minnesota
and Recommendations for Improvement**

November 2007

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EXECUTIVE SUMMARY

Faced with a growing demand for transporting patients with behavioral or psychiatric disorders, Minnesota's ambulance providers are searching for ways to meet the need. A major concern expressed by the ambulance industry has not only been the growing number of these transports, but the distances patients must be transported to an available psychiatric treatment facility. In response to these concerns, the Emergency Medical Services Regulatory Board (EMSRB or Board) created the EMS Behavioral Health Work Group to examine the issues and recommend solutions. This report summarizes the efforts of the work group, its findings and recommendations.

In creating the work group, the Board made efforts to draw from all parties affected by the problem to assure that any recommendations served the patients as well as the providers. During the course of the monthly meetings from April through September of 2007, all parties were encouraged to share concerns from their respective points of view. While much anecdotal information was shared, objective data was also examined.

Through the Minnesota State Ambulance Reporting (MNSTAR) system, the Board has collected data on all ambulance runs since mid 2003. MNSTAR data substantiated the increasing demand, both in number of interfacility transports of patients with behavioral/psychiatric disorders and in the growing length of time involved in these transports. The total number of behavioral disorder transports increased by 23% from 2005 to 2006. Compared with other non-psychiatric interfacility transports in 2006, behavioral health transports, on average, took over one and one-half times (51%) longer. Work group members agreed that the distance which many patients had to travel for admission to a psychiatric facility is a concern that needs a solution.

The Minnesota Department of Human Services has developed and expanded an array of mental health services in recent years, which in the long term should help address the problems. It appears that one of the more promising options, the nine (soon to be ten) 16-bed Community Behavioral Health Hospitals (CBHHs) that have opened since 2006 across the state, are still too new or not yet functioning at a level to have entirely relieved the pressure on the system. Hospital emergency departments are far too frequently housing psychiatric patients until suitable placements can be found, and patients are far too often traveling great distances from their community support networks in search of admission. Whether it is the ambulance or law enforcement transporting the patient, the transporting agency is feeling the strain on their budget and the toll it is taking on their other responsibilities.

After examining the problem, the work group agreed upon some recommendations that may offer some solutions. Several of the recommendations are focused on system-wide changes, which are beyond the sphere of the group's influence or ability to change, such as increasing the number of beds for behavioral health patients and supporting changes in Medicare reimbursement for ambulance service, especially for long distance transports. Other recommendations, however, focus on solutions closer to home, including pilot testing a new bed tracking system for locating psychiatric beds and promoting the use of crisis response teams in emergency departments for assessment, de-escalation, determining mode of transport and locating suitable placements. There are additional findings and recommendations contained in this report which should be of interest to

lawmakers, mental health advocates and healthcare providers alike. Hopefully, this report will stimulate further dialog and opportunities for creative solutions.



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INTRODUCTION

Minnesota's emergency medical services (EMS) providers are experiencing an increasing demand for transport of persons with behavioral health or psychiatric disorders in recent years. This growing need has presented unique challenges to emergency medical services (EMS) providers. The patient care needs of these patients generally do not include treatment of the classic medical conditions or traumatic injuries for which EMS providers are so well trained. More notable, however, is the extended distances involved in transporting persons in need of psychiatric care to appropriate mental health facilities. The need to ensure that appropriate transportation to mental health treatment facilities is available to persons with behavioral/psychiatric conditions is a concern for all affected. The Emergency Medical Services Regulatory Board (EMSRB) responded by establishing a Behavioral Health EMS work group to study this complex issue (Appendix A). This report is intended to provide an overview of the work group's efforts, findings and recommendations.

The EMSRB solicited membership for the work group from a variety of interested parties, including the ambulance industry, emergency physicians, hospitals, law enforcement, mental health professionals, the Minnesota Departments of Health and Human Services, patient advocates, state legislators, special transportation services (STS), and representatives of the Emergency Medical Services Regulatory Board (Appendix B). The work group met in May, June, July and September of 2007. Members examined the characteristics and trends in psychiatric transports, challenges presented to ambulance services in transports, factors affecting the frequency, length and time of day of these transports, and other relevant issues.

The **GOALS** of the Behavioral Health EMS work were the following:

- Recommend improvements in EMS transport to mental health treatment facilities within the constraints of existing resources.
- Recommend best practices in EMS management of psychiatric transports and opportunities for improved coordination and treatment of psychiatric patients that might reduce the demands on the EMS system.
- Identify training and resources needed to improve management of psychiatric transports or reduce demand.
- Determine the need for legislative or other policy recommendations to reduce these demands on the EMS and health care system.

The work group also established the following **PRINCIPLES** to guide its work:

- Preserve limited and critical EMS resources.
- Emphasize crisis prevention, de-escalation and emergency department diversion as preferred over hospital admission.

- Minimize the stress on transported patients and families.
- Use the least restrictive transport mode appropriate.
- Evaluate transport requests from dispatch and from hospitals for urgency and patient condition and triage for the most appropriate response time, mode (ambulance, Special Transport Services (STS), law enforcement, etc.) and nearest available designation.
- Develop adequate EMS standby response capacity.
- Minimize long EMS transports, which create a strain both on patients and the health care system.
- Support adequate reimbursement for long, costly EMS transports.
- Use a systems approach to planning and funding emergency mental health services and emergency medical services.

BACKGROUND

Anecdotal reports from the ambulance industry provide evidence to indicate that Minnesota's EMS providers are facing increasing challenges in meeting the demand for behavioral health transports. One purpose of the EMS Behavioral Health work group was to examine the actual data to determine any trends, briefly examine the causes, and make recommendations for best practice solutions. The work group examined six areas:

- Minnesota State Ambulance Reporting (MNSTAR) data
- Related studies
- Medical/treatment resources
- Perspectives of different interest groups
- The Crisis Response Team (CRT) model
- Reimbursement for ambulance transport

Minnesota State Ambulance Reporting (MNSTAR) Data

EMSRB staff provided a variety of summary reports using MNSTAR data collected from all Minnesota ambulance services for the years of 2004, 2005 and 2006. MNSTAR data illustrated that behavioral/psychiatric disorder calls in 2006 were 4 percent of all 911 emergency calls and 8.6 percent of all inter-facility/medical transport calls. Thus, as a proportion of call type, inter-facility transfer requests exceeded 911 emergency responses. In addition, MNSTAR data revealed that of the total 5,454 psychiatric inter-facility/medical transports in 2006, the majority (3,336) utilized basic life support (BLS) care, compared with the higher level of care provided by an advanced life support (ALS) response (2,089).

In Figures 1 and 2, the graphs show the number of behavioral health ambulance transports compared with all other non-psychiatric ambulance transports for 2006. (These are inter-facility transports and do not include 911 responses). The same graphs also provide data on the time involved in behavioral health transports compared with all other non-psychiatric transports. In the first two graphs (Figures 1 and 2) the time interval data reflect the hours involved with one-way transports only (measured from the time the ambulance left the hospital with the patient on board until arrival at the destination hospital). **The data does not reflect the return trip during which ambulances were unavailable to respond to other requests for service.**

...behavioral health transports are, on average, 51% longer (in minutes) than other transports.

MNSTAR data show the average one-way transport time for 2006 behavioral health transports was 56 minutes, compared with an average of 37 minutes for other inter-facility transfers (excluding behavioral health). **Thus, behavioral/psychiatric disorder transports, on average, are 51% longer (in minutes) than other**

non-psychiatric) inter-facility transports. Again, this average transport time represents only one-way trips and does not account for the additional time involved with return trips.¹

¹ MNSTAR data reflects only those patients transported by ambulance. Similar data for persons transported to mental health treatment facilities by law enforcement officials is unknown because this data is not tracked on a statewide basis.

**2006: Number of Behavioral / Psychiatric Disorder Calls
(Interfacility Transfers and Medical Transports)**

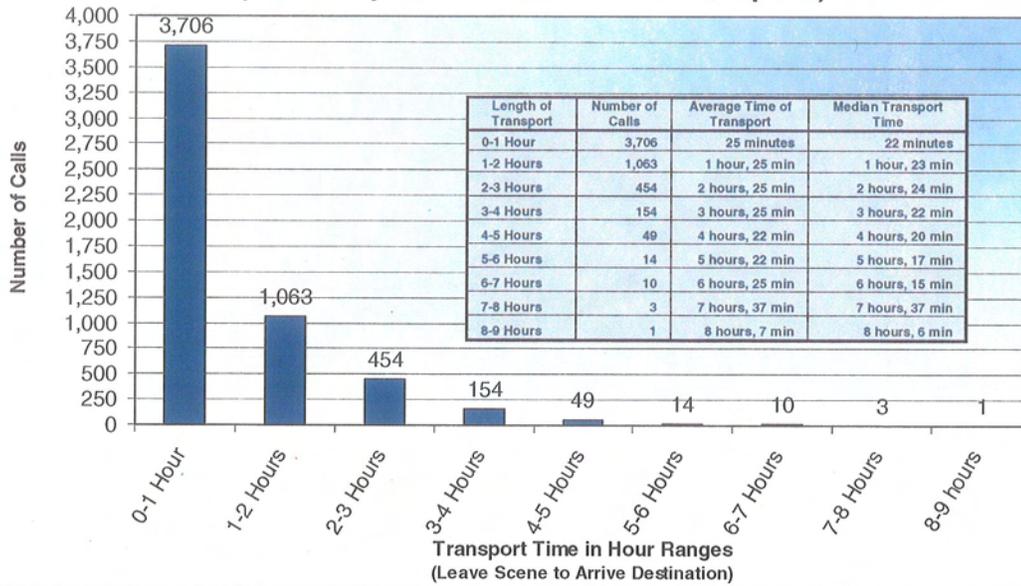


Figure 1

**2006: Number of Provider Impression Calls
(Excluding: Behavioral / Psychiatric Disorder)
(Interfacility Transfers and Medical Transports)**

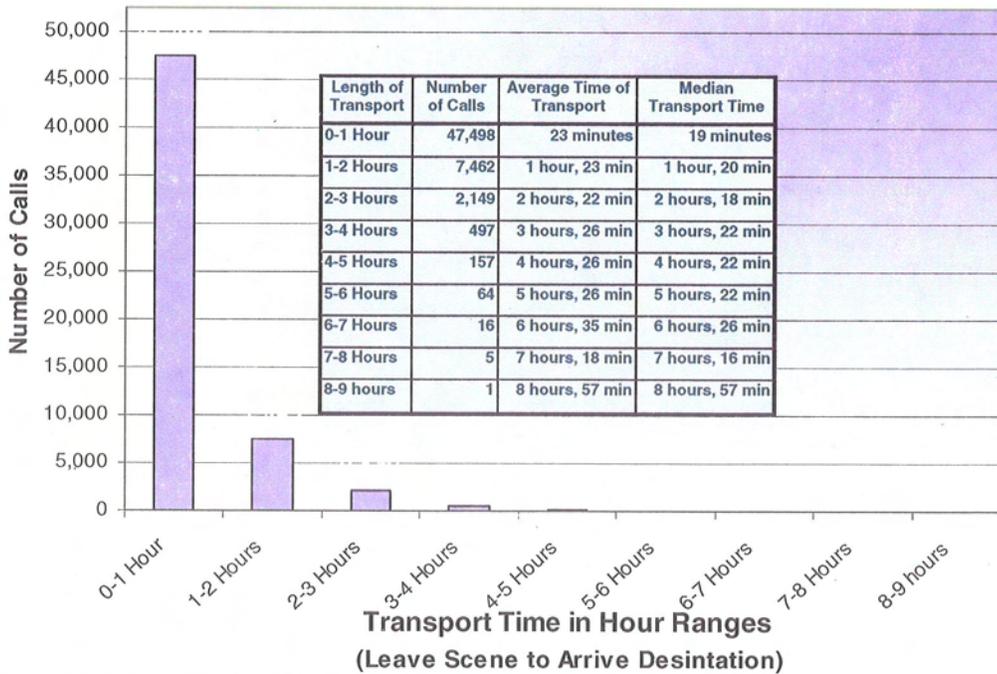


Figure 2

Figure 3 and Table 1 compare the number of behavioral/psychiatric disorder calls in 2004, 2005 and 2006 by blocks of time. Time is measured from the time of call to time back in service (after leaving the patient at the hospital). The number of behavioral/psychiatric transports increased each year with 4,498 in 2004, 4,503 in 2005 and 5,543 in 2006. Although the increase between 2004 and 2005 was not significant (5 more) the number of behavioral health transports increased between 2005 and 2006 by an additional 1040 transports, a 23 percent increase.

Figure 3

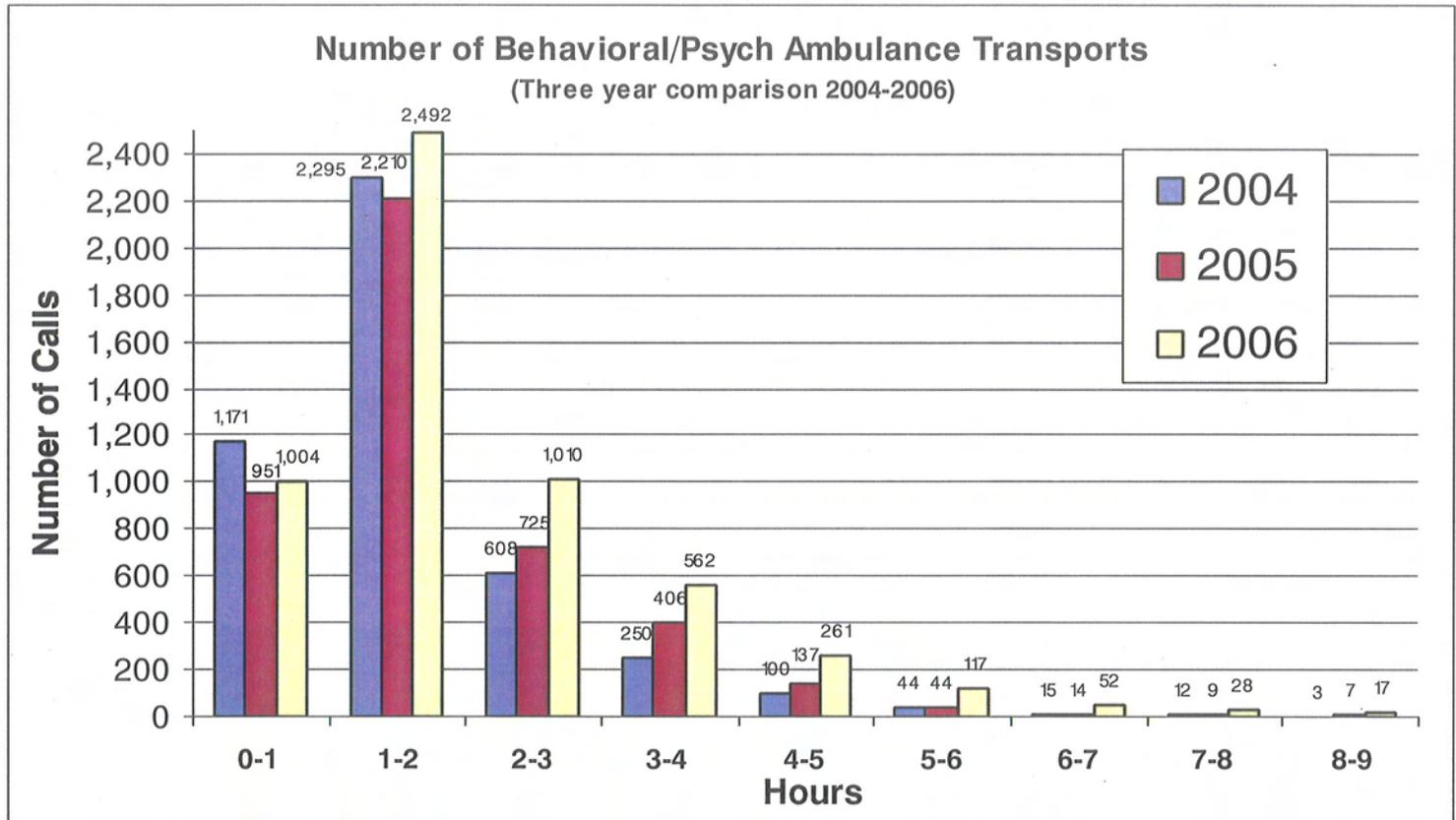


Table 1

Psychiatric transport times 2004-2006				
Hours	2004	2005	2006	Totals
0-1	1,171	951	1,004	3,126
1-2	2,295	2,210	2,492	6,997
2-3	608	725	1,010	2,343
3-4	250	406	562	1,218
4-5	100	137	261	498
5-6	44	44	117	205
6-7	15	14	52	81
7-8	12	9	28	49
8-9	3	7	17	27
Total	4,498	4,503	5,543	14,544

There has also been a significant increase in the time necessary for behavioral/psychiatric disorder interfacility transports between 2005 and 2006. Table 1 illustrates that the number of transports by one-hour blocks of time. According to the MNSTAR data, in 2004 there were 1032 behavioral/psychiatric disorder transports that took between 2 to 9 hours. This increased in 2005 to 1342 such transports. In 2006, the most recent year for which data is available, there were 2047 such transports that ranged in time from 2 to 9 hours. This data shows a 50% increase in long distance (2-9 hours, one way) behavioral/psychiatric transports from 2005 to 2006.

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Ambulance providers report that many of the interfacility transport requests for behavioral health patients are during night time hours (between 10:00 p.m. and 7:00 a.m.) A query of the MNSTAR data for 2006 found that of the 5566 such transports, 1,441 or 26% began between these nighttime hours. Long-distance, night time transports create a strain on ambulance services which typically have fewer staff on duty during these hours. Night time driving also poses a greater safety risk.

Related Studies

A retrospective study of MNSTAR data was completed by a team from the Mayo Clinic. An abstract of this study can be found in the Research Forum Abstracts of *Annals of Emergency Medicine* (Volume 48, No. 4. CC Kwon, MD Sztajnkrycer, DG Hankins). The nature of pre-hospital and inter-facility emergency psychiatric care at a statewide level during a 12 month period from June 2004 to June 2005 was reviewed. The study revealed that of a total of 422,939 ambulance runs, 17,566 or 4.2 percent involved behavioral or psychiatric disorders. Chemical restraints were used on 1.5% of the runs. The authors recommended that EMS agencies evaluate if their providers have sufficient level-specific resources for these potentially high risk patients.

The *Twin Cities Patient Flow Study* completed by 10 hospitals in the Minneapolis St. Paul metropolitan area and the Anoka County Metro Regional Treatment Center (Fall 2006) examined the use of emergency departments and adult inpatient psychiatric units by persons experiencing a mental health crisis. (Appendix C) The three-month study found that 40 to 50 patients a month who arrived at metro area hospital emergency departments were admitted to inpatient units because they do not have access to less intensive mental health services. The study results also indicated that 240 to 250 patients per month have “non-acute” days in the hospital, suggesting that patients would spend less time in the hospital if adequate transfer/discharge options were available. The study identified the need to create a work group with representative from multiple disciplines and agencies to develop short and long term recommendations. (Note: The east metro group has begun meeting and the west metro group will be convening in late 2007.) The study also found that there was a need for lawmakers to provide funding for community treatment alternatives, housing and crisis care, and to provide appropriate level of care to patients and the system. The 2007 Legislative session resulted in a significant investment of funds to support community-based mental health and related services such as housing. Services implemented with these funds will begin to address the current gaps in the mental health delivery system.

Medical/Treatment Resources

During the last two to three decades, the nation has undergone a major shift in treating persons with mental illness by closing large state-supported institutions and offering community-based alternatives. Minnesota has followed that trend and has gradually closed most of the state's regional treatment centers, commonly referred to as "state hospitals". In place of the state hospitals, the Minnesota Department of Human Services (DHS) has developed a myriad of treatment options, which are described below. (Appendix D)

- Assertive Community Treatment (ACT) is a Medicaid reimbursed service provided by multidisciplinary treatment teams with low client to staff ratios (10-1). ACT is for persons who have the most serious mental illnesses and have not benefited from conventional community care. ACT was implemented in 2005. There are currently 26 teams located throughout the state.
- Intensive Residential Treatment Services (IRTS) are short-term, time-limited Medicaid reimbursed services provided in residential settings for people who are at risk of significant functional deterioration if they do not receive this level of supervision and treatment. IRTS were implemented in 2004. There are currently 32 treatment facilities across the state.
- Adult Rehabilitation Mental Health Services (ARMHS) is a Medicaid funding stream permitting rehabilitation services provided one-to-one or in groups within the home or community by qualified staff. ARMHS began in 2002 with five providers. There are currently 111 providers, which provide service in all 87 counties.
- Medicaid (MA) Crisis Response Services respond to the needs of people experiencing a mental health crisis or emergency, and in some cases this includes short-term needs for other interventions. Crisis Services operate under contract with a county(ies) and began operating in 2003. There are currently 28 crisis providers in 31 counties. Not all providers offer 365 day, 24/7 services.
- Community-Based Extended Psychiatric Hospital Beds provide extended psychiatric inpatient services to individuals who are recipients of Medical Assistance or who are, underinsured or uninsured and who are either under civil commitment or require longer inpatient care because of clinical considerations. Sixteen community hospitals with inpatient psychiatric units are under contract with DHS. The hospitals are located across the state.
- Community Alternatives for Disabled Individuals (CADI) is a comprehensive package of Medical Assistance services, used to provide care and support for people living at home rather than in a nursing home. These services are provided to approximately 9,000 individuals annually.
- Community Behavioral Health Hospitals (CBHH) are 16-bed State-operated treatment facilities located across greater Minnesota for persons in need of acute mental health

inpatient treatment. DHS began operating CBHHs in 2006. Currently, nine of the ten CBHHs are in operation. Due to shortages of key staff, several of them are not yet at full capacity.

According to DHS, the total number of mental health beds now available in Greater Minnesota under the various options exceeds the number previously available in the State's regional treatment centers. In addition to Anoka Regional Treatment Center, there is one regional treatment center in operation (Willmar) which will continue to operate until there are a sufficient number of CBHH beds available. There are some noteworthy differences in the new CBHHs when compared with state hospitals. A Greater Minnesota patient's average length of stay has decreased from approximately 45 days at a state hospital to an average of 19 days at a CBHH. There are no 24/7 primary care clinicians available at CBHHs. The CBHHs contract for their primary care services from the community clinics. As stand alone mental health units, the CBHHs cannot serve patients with primary care conditions that require inpatient observation and treatment or convalescent care. This creates a need for medical clearance before patients can be admitted, which is a challenge that did not exist under state hospital system.

Utilization of beds for psychiatric patients, as reported to Minnesota Department of Health (MDH), increased in most community hospitals with psychiatric units between 1995 and 2005. An increasing number of psychiatric patients have been admitted to psychiatric units through hospital emergency department and mental health patients travel for care more than all other patients combined. This information is based upon mandated hospital reporting and an analysis of hospital insurance claims. MDH will be publishing a report on psychiatric bed utilization by early 2008. (Appendix E) According to data from the Minnesota Disability Law Center, in 2006 alone, 76 patients from Minnesota were admitted with hold orders to psychiatric beds at Prairie St. Johns in Fargo, North Dakota. While several of those hold orders originated in western Minnesota counties, more than half originated in counties much further east, including Anoka (23), Hennepin (4), Ramsey (4) and Olmsted (3), all of which are at least a 3 to 4 hour drive.

The Minnesota Hospital Association, under contract with DHS, is in the final stages of piloting an online interactive mental health inpatient bed tracking system. The first phase is for community psychiatric hospital beds across the state beginning with the metro area. The second phase will include community-based services such as crisis stabilization beds and Intensive Residential Treatment Services. The hospitals have agreed to input the necessary data. The intent is to be able to locate an available psychiatric bed via the Web, rather than having to make a series of telephone inquiries. It is also intended that the patients will be able to be treated more closely to their home communities, rather than having to travel several hours to an available treatment facility.

Perspectives of Different Interest Groups

The work group was comprised of individuals representing different interests and time was allotted on the agenda to share the varying perspectives. Included in these perspectives were those of the patient advocates, law enforcement, the ambulance and special transportation services industries, hospitals and emergency physicians. Work group members recognized that behavioral health

patients present complex clinical issues and there are many variables to be considered in triage and transport.

The patient advocates' issues included the desire to reduce demand for transports; better training for those interacting with patients; the lack of crisis services and the use of restraints. The least amount of restraint is ideal; this includes physical and chemical restraints. There is also the perspective that when law enforcement transports patients, there is a tendency to view the transport as a criminal matter, rather than as a person seeking treatment for an illness. The question was raised if it was necessary to utilize 72-hour or transport hold orders with patients who voluntarily seek admission, as some ambulance services said they required a hold order before transporting a psychiatric patient between facilities. The mental health advocates tended to agree with ambulance providers that additional mental health treatment facilities and crisis prevention services would improve conditions for patients and their families.

Local law enforcement plays a major role in behavioral health transports. While there is no statewide data tracking the frequency of or where law enforcement officers transport mental health patients, anecdotal information and data recorded by individual sheriffs' offices suggest that a significant amount of law enforcement resources are used to deliver persons to mental health treatment facilities. (Appendix F) In addition to transporting patients to psychiatric hospitals or facilities for care, sheriff's offices throughout the state regularly transport these patients back to their home county for civil commitment hearings. After a patient is admitted to a treatment facility, the sheriff must often return to the treatment facility to transport the patient to the Court House pursuant to judicial transport orders.

The Anoka County Sheriff's Office, which transports a large number of behavioral health patients to and from civil commitment hearings at the Anoka County Court House, describes the challenges faced when patients are placed in treatment facilities far from Anoka County:

Patients (especially those transported from out-state locations) are away from treatment facilities for extended periods of time. The time away from treatment facilities has had a negative impact on the condition of already fragile patients.

Because patients have early morning pick-ups, there are occasions when they miss breakfast and prescribed medications. They arrive at the court house and wait for the hearing, regularly extending from morning hours into late afternoon. No medications are passed to the patients while in the court house complex. If patients are waiting through the lunch recess, they are fed a bag lunch from the Jail Division. Medical conditions of these patients have deteriorated during the period of time they are in the court house complex. Because no medical attention is available in the complex, the Sheriff's Office has had to call 911 for an ambulance. This has resulted in court continuance and additional transports for the patients. If county social workers cannot find a bed locally or within the metro area on the date of the court appearance, the patients are returned to out-state locations, arriving at the treatment facility during the evening, missing meals.

The more problematic situations for this law enforcement agency are transports from facilities located 3 to 4 hours travel time from Anoka County. Overtime costs for the Court Security/Transport Unit have more than doubled from 2005 to 2006, directly related to transport assignments.

On two occasions in July/August of 2007, deputies worked 22 hour days to accomplish the pick-up of a patient, transport to the court house, and return to the treatment facility. Long work days remove deputies from other work assignments, create liability and safety issues for the agency, and place civil commitment patients at further risk, emotionally and physically.

Example: On 7/31/07, pursuant to a court issued transport order, two deputies left Anoka at 4:00 a.m. to drive to Worthington, Minnesota, to transport a civil commitment patient back to the Anoka County Court House for a court appearance. The patient arrived at the Anoka County Court House at 12:30 p.m. to await the hearing and meet with the doctor and public defender. The court hearing ended at 5:00 p.m.

Because no bed could be found by the county social worker at the appearance (either locally or in the metro area) the patient was ordered returned to the treatment facility in Worthington. The patient was transported (by the same two deputies) back to Worthington. Because of the length of the day and concern for the patient, Sheriff's deputies provided a fast food meal to the patient at 5:23 p.m. The patient arrived back at the treatment facility at 9:35 p.m. The deputies returned to Anoka County, ending their shift at 2:00 a.m. the following day, 8-01-07. The deputies were required to report for work at 7:30 a.m. on 8-01-07, only 5-1/2 hours off the clock. This transport required a 22 hour continuous shift for law enforcement, 982 miles driven, 14 hours overtime for each deputy, and over a 10 hour day for the patient away from the treatment facility and any patient care, for a single patient.

The same day long-distance transports occur; other patients are also scheduled and brought in from additional treatment facilities for court. On the date of the above example, patients were transported from Willmar, Annandale, Minneapolis, and Coon Rapids. Because the number of deputies required for transports exceeded the staffing capability, two deputies were re-allocated from civil process duties to conduct transports. This meant the service of time sensitive papers were delayed, papers were not served, and other assignments were put on hold.

Law enforcement agencies are unable to provide specialized patient care. For example, patients who are non-ambulatory or who require an insulin injection during transit would be inappropriate law enforcement transports. In Anoka County, an Allina ambulance would be contacted by the Sheriff's Office and requested to conduct these transports.

Some ambulance services questioned the need for ambulances when patients appear to have no need for medical interventions during the transport. Ambulance services may, if there is no

medical necessity, suggest that the transport of behavioral health patients be done by regular vehicle (private car or law enforcement). The problem lies in what is considered a “medical necessity.” There is no standard definition and it is basically determined by the requesting physician. (Appendix G). It is reported that emergency department physicians will document a medical necessity to have a behavioral health patient transported by ambulance, freeing their hospital’s bed for another patient. EMS providers reported that the length of transports in the past two years has increased, as well as the number of transports to out of state facilities. They contend it is more difficult to staff for these long distant transports, and there is a lack of coordination between transports to and from the metro area.

It is likely that behavioral health patients were more frequently transported by STS (also known as para-transit) providers in the past. STS is transportation for those not requiring the level of patient care provided in an ambulance. The STS industry is not regulated by the EMSRB, but by the Minnesota Department of Transportation. Drivers and patient assistants are trained to care for vulnerable adults and provide first aid. They must also have driver training and background checks. The STS personnel are not emergency medical technicians (EMTs).

According to the representative of the special transportation services (STS), since DHS began using a broker for non-emergency medical transportation in 2004, this industry has lost 130 companies statewide and there is no longer 24-hour, 7 days a week coverage in the metro area. Because of the reduction in STS providers, many of the patients are being referred to EMS for transport to psychiatric facilities. Under current DHS requirements, STS requests for services must be approved by an out-of-state broker before they can occur and this causes significant delays. It appears likely that the reduction in STS providers in the metro area has led to an increased demand for ambulance transport services.

Emergency department physicians reported difficulty in finding appropriate psychiatric beds and the reluctance of some hospitals to “give up” a bed to a psychiatric patient. In regard to the Web-based hospital bed tracking system that is currently being piloted, some question if hospitals will accurately report bed availability.

Crisis Response Team Model

Meds-1 Ambulance in Grand Rapids, Minnesota, utilizes a crisis response team (CRT) when responding to patients with behavioral/psychiatric disorders. The Crisis Response Team Model was developed in Itasca County through a group effort among ambulance services, hospitals, law enforcement and mental health professionals. Meds-1 Ambulance is the Advanced Life Support (ALS) ambulance in the county responding to approximately 3,000 calls a year. The Crisis Response Team (CRT) was developed in 1999 and is funded by the county through a grant. The CRT has 21 members, all of whom are mental health providers. The CRT model was developed after the closure of an inpatient psychiatric unit in the county. Law enforcement had concerns about taking patients to facilities without an appropriate evaluation. There was no method for determining which mode of transport should be used. Furthermore, the three hospitals in the county each had different ways of assessing patients.

A member of the CRT responds to the hospital emergency department to evaluate the patient. An ambulance transport is requested when certain criteria are met. Approximately 50 percent of the transports involve CRT transports in a county vehicle and the other half are transported via ambulance. A CRT member accompanies all patients to assist with de-escalation on the ambulance or as the driver of the car if an ambulance is not required. If the patient is transported by ambulance, they are also assessed for medical needs en route. The ambulance crew and CRT member work with the hospitals to ensure that the patient is triaged to the appropriate facility. Phone calls are made before transport to ensure psychiatric bed availability.

Because reimbursement for ambulance transport is limited to the closest available bed, the CRT assures that the closest appropriate facility is selected. Meds-1 has not had a problem with third-party billing and Itasca County has agreed to reimburse at the Medicaid rate when all other options are exhausted. Meds-1 Ambulance designated the CRT as a business associate for purposes of HIPAA. The 911 operator dispatches a CRT member as well as the ambulance for all behavioral health emergencies.

The CRT members are employees of a 3rd party, not-for-profit entity and have a minimum of a bachelor's degree with additional crisis training. The CRT member consults with the emergency department physician. Although hospital evaluation time is increased, it does not directly involve emergency department personnel because a CRT team member is always with the patient. If a hold order is required, the CRT members can issue it on behalf of the County Health Officer. Prior to discharge, a CRT team member is contacted to allow follow up with the patient and after-care planning.

The Crisis Response Team Model in Itasca County evolved over time and has resulted in fewer behavioral health transports by ambulance (approximately 50 percent of behavioral health calls). There is increased success in locating appropriate beds in the area, often in Hibbing or Duluth. Only twice in the last year have they had to travel long distances.

Itasca County does not use special transportation services (STS) or wheelchair vans for psychiatric transports since transport by a CRT member is an option, provided an ambulance is not required.

Reimbursement for Ambulance Transport

The issue of reimbursement continues to be a concern in behavioral health transports. The work group heard presentations from North Memorial and HealthEast Transportation regarding current reimbursement. North Memorial Ambulance provided the following statistics for the month of January 2007: Of 42 out-state (35 to 230 miles) transports, Medicare and/or Medicaid paid 55 percent of the claims, HMOs paid 36 percent, 9 percent were self-pay, 7.5 percent were bad debt. North Memorial receives 3 to 5 percent less reimbursement for behavioral health transports than for the average transport. North Memorial management estimates that behavioral health transports cost between \$600 and \$1,000 per call. Most of these calls require overtime because of the transporting distance, and additional crews are often necessary. North Memorial Transportation reported that not only is the reimbursement by Medicare inadequate, it can be six to seven months before payment is received. In contrast, HMOs usually reimburse within in three to four months.

HealthEast Transportation reported on reimbursement for out-of-town transports from January to June of 2007. The statistics indicated there were 54 behavioral/psychiatric disorder transports (an average of nine per month). The average transport distance was 96 miles per patient. Of those billed, 51 percent were paid, 32 percent were charged less than billed (due to contracts), 17 percent were private pay or bad debt, 42 percent were covered by HMOs, and 21 percent were paid by Medicaid and/or Medicare. HealthEast representatives reported that Medical Assistance payments are an additional challenge because of the documentation required and lack of electronic billing.

Both ambulance services reported having some of the same reimbursement issues. Reimbursement rates for Medicare Basic Life Support (BLS) are an average of \$230 base rate plus mileage and the ALS base rate is approximately \$300. When both Medicare/Medicaid pay the reimbursement, it is approximately 45 cents on the dollar.

The billing process for Medicare/Medicaid requires a physician certification statement (PCS), which documents the medical necessity for ambulance transport. If the documentation is incomplete, additional information is requested before the bill can be submitted. Documentation must be provided to determine insurance eligibility. Patient records must document that the person was transported to the nearest appropriate facility. A reason must be provided for each transport. Once the claim is submitted, payment is not guaranteed, and ambulance services report that payers too often unduly scrutinize or reject ambulance claims. Staff spend considerable time in reviewing pending claims. The information patients provide to Medicare/Medicaid may be incomplete or unusable. Some claims end up being referred to collection agencies or revenue recapture.

State law prohibits ambulance services from denying emergency ambulance service because of inability to pay or because of the source of payment, but transport may be limited to the closest appropriate facility. Payers also often require transport to the closest appropriate facility. For inter-facility transports, the sending facility selects the receiving facility and then calls for ambulance transport. If the sending facility selects a receiving facility the payer judges not to be the closest facility, the ambulance claim can be denied even though the ambulance had no control over the destination.

IDEAL OUTCOMES, ISSUES DISCUSSION

During the course of the discussions of the EMS Behavioral Health work group, it became apparent that the underlying causes of the problems at issue were much larger than what could be fully addressed by the work group. The state's mental health treatment system, for example, is critical in resolving the concerns but outside the work group's ability to tackle. This realization, however, did not deter the work group from focusing its discussion on the following ideal outcomes:

- Reduce the demand for EMS mental health transports and increase the efficiency of EMS behavioral health responses.
- Adjust reimbursement and regulations to adequately cover the cost of EMS behavioral health transports and allow the most appropriate EMS response.
- Promote the adoption of EMS and related best practices for behavioral health response and transports, both clinical and non-clinical.
- Support improvements in the mental health system related to the role of the EMS system.

Reduce Demand

An analysis of the data, both anecdotal and statistical, indicated that the demand for ambulance transport of patients with psychiatric disorders has substantially increased in recent years. The increased demand has diverted resources from functions traditionally performed by the EMS system. Not only must ambulance services change staffing patterns and personnel training to meet this need, but they must continue to be available for 911 emergency response, as well as specialized needs. One example was provided by Life Link III, a metropolitan-based ambulance service whose specialty is critical care, interfacility transports throughout the state. Life Link management expressed concern with routine psychiatric transports diverting resources from other specialized transports, such as neonatal transports, which few other ambulance services perform. HealthEast Transportation, another metropolitan-based service specializing in interfacility transports, indicated that at times when transporting psychiatric patients to the CBHH facilities outside of the metro area, they have been turned away because there is no physician on site.

On the positive side, Meds-1 Ambulance in Grand Rapids offered some solutions that have been successful in reducing the demand in Itasca County. This northern Minnesota ALS service explained their collaboration within the county in implementing Crisis Response Teams (CRTs). Meds-1 worked with the local mental health community to assist in developing triage and referral procedures for community based alternatives for psychiatric patients. A mental health professional is dispatched to the scene to assess the behavioral health patient and determines if the patient requires transport by ambulance or by car driven by the CRT member. Regardless of the mode of transport, the CRT member always accompanies the patient. The CRT member is also able to track bed availability for crisis patients. This approach has been successful in reducing the demand for ambulance transport of patients with behavioral/psychiatric disorders by an estimated 50 percent.

Reimbursement for Psychiatric Transports

As the number of transports increase along with length of transports, discussion regarding reimbursement recurs. The findings suggest that reimbursement to ambulance services for psychiatric transports falls short of covering costs incurred, primarily for long distance transports. Transporting patients from metropolitan hospitals to psychiatric facilities far from the metro area creates staffing challenges, for both ambulance services and law enforcement. An Allina representative estimated that its ambulances log an extra 100,000 miles per year (a 25% increase) for psychiatric patient transports. Ambulance providers also noted the Medical Assistance claims are the only bills they cannot process electronically which creates additional work. Law enforcement personnel provided a summary of transport costs associated with civil commitments for the Anoka County Sheriff's Office, when psychiatric patients who have been admitted to hospitals far from Anoka County must be transported back for hearings. Anoka County's 2006 data indicates that law the Sheriff's office performed 1,156 transports of patients for civil commitment hearings, logging 35,419 miles, at a cost of \$126,559. Other representation from law enforcement stated they could transport patients more often but there is no funding for these transports. Using special transportation services (STS) providers, when there is no medical necessity for ambulance transport, could potentially help ameliorate the problem. The findings suggest that the recent decrease in the number of STS providers may have exacerbated the demand on ambulance services which are now being used for less acute transports previously performed by STS providers.

Best Practices

The adoption of best practices was discussed but not entirely resolved. The issues included: staffing (both EMS and hospital); better coordination in locating psychiatric beds; pre-crisis intervention; training needs (EMS staff and system); reducing inappropriate discharges and admissions, including repeat transports (patients returning after 72 hour hold ends); and the need for regulatory relief.

Staffing: In regard to staffing, much of the discussion focused on the availability of psychiatric beds. While there may be more licensed hospital / treatment facility beds available, the ability to staff these beds is problematic, both with nurses and/or psychiatrists. The staffing problem is compounded when a patient is ready to be discharged but there is no suitable place for the patient to go. While there may be best practice options to address this concern, it seems that it is a product of the healthcare staffing shortage.

With regard to ambulance staffing, the question arose if ambulance services are required to accept interfacility transport requests for mental health patients. The decision to transport by ambulance or other means essentially is determined by the physician requesting the transfer, and whether there is a medical necessity for ambulance transport. In some communities where ambulance coverage is provided by a small volunteer service with limited resources, a long distance transport is not always an option, and another ambulance service may need to be located. Some ambulance providers reported requiring the patient be under a hold order before transporting from one facility to another. While state statute requires that emergency transport not be denied due to inability to

pay, it only requires that the patient be taken to the closest appropriate facility. The focus of this group's concern has not been the 911 emergency calls, but the request to transport a patient from a hospital emergency department to another treatment facility where a psychiatric bed had been located, often a lengthy transport.

Locating nearby psychiatric beds: The problem with locating psychiatric beds or appropriate mental health treatment options is particularly problematic in the metro area. While the opening of the nine community behavioral health hospitals (CBHHs) in Greater Minnesota has been helpful, this option has done little for patients from the metro area because CBHHs do not accept metro patients. Ambulance services continue to criss-cross the state in search of available psychiatric beds. The recent implementation of the web-based psychiatric bed tracking tool by the Minnesota Hospital Association shows promise in locating beds for psychiatric patients in metro area hospitals.

Training: It was also noted that ambulance personnel receive little, if any, training on caring for patients exhibiting signs of mental illness. Such training is not a part of the EMT-Basic curriculum, but could and should be offered as continuing education for EMT-Basics and EMT-Paramedics. Organizations, such as the Barbara Schneider Foundation, have recently developed training for law enforcement and EMS agencies on de-escalating techniques to be used with mentally ill patients in crisis situations.

Mental health experts reported that persons with mental illness often avoid seeking treatment due to the shame and humiliation associated with the illness. This reluctance often leads to little or no treatment until they have a full-blown crisis, landing them in a hospital emergency department or jail. Inappropriate interventions by untrained law enforcement officers or medical personnel can add to the humiliation and escalate the patient's crisis condition. It is critical that mentally ill persons be treated in a compassionate manner, while ensuring the safety of both the patient and the responding personnel.

Pre-Crisis Intervention: The information provided by the Department of Human Services on mental health treatment options shows that progress has been made in recent years with the continued development of additional services. Many of these service options are new and will hopefully be more easily accessed after they become better established and known. Nine Community Behavioral Health Hospitals (CBHHs) have opened in the last two years. Discussions indicated the CBHHs are not meeting the need as quickly as they should since patients often have to wait several hours until admission arrangements are made.

Social workers and mental health case managers are needed for persons with mental illness in order to access less restrictive alternatives. In some counties, individuals who are in the public system and who have a serious and persistent mental illness can only access targeted case management services if they have been admitted to a hospital or are under civil commitment.

Suggestions were made that to minimize stress when transporting a patient, there should be appropriate dialog with the family, with a goal of having more knowledge of who to talk to before the transport. Anoka County Sheriff's Department showed that in 2006 they transported 4,566 patients, of which 1,202 were civil commitments. As patients wait for court hearings their

conditions often deteriorate and they may need to call an ambulance. Patients that are hospitalized in Fargo present a real problem, especially when they are scheduled for a court hearing with a one-day notice and must be transported back to Anoka.

Regulatory Issues: According to some emergency physicians participating in the work group, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) holds the transferring physician responsible for the patient. Because of this liability, there is an incentive to order that the patient be transported by ambulance, often by an advanced life support (ALS) ambulance which has the ability to administer medications, rather than by a less costly alternative. Some ambulance providers reported that while transporting at the ALS level, they will only be reimbursed at the lower BLS rate.

Improvements to the Mental Health System Relating to EMS

A topic of universal concern was how to improve various components of the mental health system. Most if not all of the suggestions already discussed would benefit EMS providers in the caring for patients with mental illness. Preventive services, community-based services and an adequate supply of treatment facilities in strategic locations, both acute beds and supportive living services, are essential to long term improvements. Of particular concern, was the need for treatment options in the metro area to avoid transporting patients great distances from their home.

RECOMMENDATIONS

This report includes a number of broad recommendations for reducing demand and improving transport of behavioral health patients. Although the work group recognized its limitations in being able to resolve such a system-wide problem, it concluded the meetings with the following list of specific recommendations:

1. Utilize the web-based bed-tracking tool, recently developed by the Minnesota Hospital Association under contract with the Department of Human Services, for locating available psychiatric beds. Test the reliability of the tracking tool through intermittent audits to ensure hospitals updating bed status in an accurate and timely matter.
2. Promote training in the care of behavioral health patients for hospital emergency department and ambulance personnel. Encourage EMS conferences to include sessions on de-escalation in behavioral crisis situations. Assure access to mental health professionals particularly in rural Minnesota where hospital emergency departments may not have trained mental health professionals on staff.
3. Develop a single mental health crisis phone number for the metro area, and consider expanding it to a single statewide number. With the constant change of crisis phone numbers in the metro area, patients are unable to easily access help prior to calling 911. A reliable crisis line may reduce the number of trips to the hospital emergency room.
4. Explore expanded use of intermediate or alternative transportation services, including Special Transportation Service (STS) providers, to assist with ambulance and law enforcement transfers for behavioral health patients when appropriate.
5. Promote alternative approaches, such as the development and implementation of Crisis Response Teams used by hospitals and ambulance providers in Itasca County.
6. Increase the number of hospital and/or community-based beds, including residential crisis and treatment options, for behavioral health patients to limit the number of patients have to be transported far from their home communities. While the total number of beds now available is purported to be equal to the number prior to the state hospital closures, there continues to be a problem of access, particularly in the metro area.
7. Support changes at the state, federal and private payer levels in billing and reimbursement, particularly for long distance transports. For example, Congress and the Minnesota Legislature should clarify for Medicare and Medical Assistance respectively that physicians' certification statements for EMTALA transfers guarantee payment by Medicare/Medical Assistance. At the state level, DHS should enable providers to submit claims electronically for Medical Assistance.
8. Amend state law to require counties to pay the cost of ambulance transport for mentally ill and/or chemically dependent persons temporarily confined for observation, evaluation, diagnosis, treatment and care, if the person does not have health insurance coverage. Minnesota Statutes § 253B.045 currently requires counties to pay for the cost of such treatment, when no health insurance is available, but does not specifically include ambulance transport.

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APPENDIX A

Board member Mark Schoenbaum moved that the EMSRB establish a work group on transporting patients with psychiatric or behavior conditions and on broader issues affecting care for psychiatric emergencies.

Membership will be appointed by the chair and include two or more EMSRB board members, representatives of the ambulance industry, hospitals, mental health professionals and/or mental health interest groups, state agencies, local law enforcement and may include others.

The work group is charged to study the characteristics and trends in transports of patients with psychiatric or behavior conditions, challenges presented to ambulance services in transporting patients with psychiatric or behavior conditions, factors affecting the frequency, length and time of day of psychiatric transports, and other relevant issues.

The work group will recommend best practices in EMS management of psychiatric transports, opportunities for improved coordination and treatment of psychiatric patients that might reduce the demands on the EMS system, and shall identify training and resources needed to improve management of psychiatric transports or reduce demand. The workgroup may also make legislative or other policy recommendations to reduce demands on the EMS and health care system by psychiatric patients in need of transport.

The work group will meet as needed. EMSRB staff will support the work group, and contributions of staff or other support from other interested parties is welcome. The work group shall report its findings and recommendations to the EMSRB by September, 2007.

Motion Passed: March 17, 2007

Minnesota Emergency Medical Services Regulatory Board

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APPENDIX B

WORK GROUP MEMBERS

Sue Abderholden	National Alliance on Mental Illness
Randall Ansley	Winona Area Ambulance Service
Sharon Autio	Minnesota Department of Human Services
Maddy Cohen	Regions Hospital
Mark Dascalos	Allina Medical Transportation
Brian Edwards	Northfield Hospital Ambulance Service
Becky Fink	Mary T. Inc
James Franklin	MN Sheriffs Association
R.J. Frascone, M.D.	Regions Hospital
Tim George	Meds-One Ambulance
Dan Hankins, M.D.	Mayo Clinic
Mary Hedges	EMSRB
Laurie Hill	Walker Ambulance
John Huot	Life Link III
Robert Jensen	Kanabec Cty Sheriff's Office
Kory Kaye, M.D.	Regions Hospital, EMSRB State Medical Director
Talia Landucci	EMSRB
Buck McAlpin	MN Ambulance Association
Kevin Miller	Dakota County Public Health
Bob Norlen	EMSRB
Mike Parrish	North Memorial Ambulance
Tammy Peterson	EMSRB
Kevin Raun	HealthEast Medical Trans.
Jim Rieber	EMSRB Board Chair
Catherine Roach	National Alliance on Mental Illness
Mark Schoenbaum	Office of Rural Health & P.C./EMSRB Board
Roger Schwab	Ombudsman for MH/DD
Karin Small	Justice Services Division Anoka Cty Sheriff's Office
Donald Snorek	Tri-County Hospital
Adam Stout	Kanabec Hospital Ambulance Service
Sue Stout	MN Hospital Association
Matt Sztajnkrzyer, M.D., Ph.D.	Mayo Clinic
Edward Van Cleave	MDH-HEP
Ben Wasmund	Lakes Region EMS
Mike Weidner	MN Para transit Provider Association
Will Wilson	Mental Health Assoc. of MN
Gary Wingrove	Gold Cross Ambulance
Diane Ollendick Wright	Supportive Living Services

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For Immediate Release

For more information, contact:

Terri Dresen, 651-241-8517

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Study sheds new light on Twin Cities' mental health care crisis

Hospitals, state and metro counties collaborate on 3-month study

ST. PAUL, Minn. 03/15/2007--A new study by major Twin Cities hospitals and the Anoka County Metro Regional Treatment Center found that 40 to 50 emergency room patients per month are admitted to metro area hospitals because they do not have access to less intensive resources. An additional 250 patients per month spend unnecessary time in inpatient psychiatric units because of a lack of residential treatment beds or other alternatives. According to estimates by hospitals, this adds up to more than \$24 million in costs to the system annually.

"There is bottleneck in the system," said Michael Trangle, MD, associate medical director of behavioral health for HealthPartners. "Our hospitals' emergency departments have become waiting rooms for patients experiencing a mental health crisis, and our inpatient psychiatry units and regional treatment center are treating patients who in many cases could be more properly cared for in less-acute care settings."

The three-month study, conducted last fall, found that among the 40 to 50 patients per month who use emergency room services because they lack access to less intensive resources:

- 35 percent lack 24/7 medical and behavioral health services or intensive residential treatment services.
- 23 percent lack substance abuse services, such as detox and chemical dependency with lodging.
- 10 percent lack access to the provider who prescribed medication.

Furthermore, patients admitted to inpatient psychiatric units would spend less time in the hospital if adequate intermediate options, such as intensive residential treatment beds, were available. As many 240 to 250 patients per month have "non-acute" days in the hospital. This adds up 2,000 to 2,100 "non-acute" days in the hospital per month.

Similarly, data collected from the Anoka Metro Regional Treatment Center show that 88 patients per month have "non-acute" days. This adds up to an average of more than 1,700 "non-acute" days per month. The study shows that more than one-half of these patients could be appropriately cared for if adequate services were available to providing both medical and behavioral health nursing or corporate foster care.

"We could potentially treat up to 2,733 more patients per year in our metro community hospitals and 344 patients per year in the Anoka Metro Regional Treatment Center if we were to devote adequate resources to intermediate care services in the community," said Paul Goering, MD, medical director, [department of psychiatry](#), United Hospital. "More than \$1.2 billion is spent each year on mental health services in Minnesota, yet the system fails to meet the needs of people with mental illness. We must do more."

The results of the study identify the need to create a work group with representatives from hospitals, state agencies, substance abuse services, intensive residential treatment services, nursing homes, and supported housing to develop practical recommendations of how to fill the gaps.

"There are proposals moving through the legislature right now that can help address these issues," said Dr. Trangle. "It's imperative that lawmakers adequately fund these measures, including community treatment alternatives, housing and crisis care, so that we can provide patients with the most appropriate level of care and alleviate bottlenecks in the system."

About the study

APPENDIX C

The Twin Cities Psychiatric Patient Flow Study was recommended by community leaders at the Roundtable Discussion on Behavioral Health held last spring. The study includes all Twin Cities hospitals that have both inpatient and emergency psychiatric departments and Anoka County Regional Treatment Center, which provides longer-term inpatient psychiatric care. Leaders from the Minnesota Department of Human Services and all seven metro county social services also contributed.

Organizations participating in the study included:

Abbott Northwestern Hospital

Anoka County Social Services

Anoka Metro Regional Treatment Center

Carver County Social Services

Dakota County Social Services

Fairview Hospital Systems

Hennepin County Medical Center

Hennepin County Social Services

Mercy Hospital

Minnesota Department of Human Services

North Memorial Hospital

Ramsey County Social Services

Regions Hospital

Scott County Social Services

St. John's Hospital

St. Joseph's Hospital

United Hospital

Washington County Social Services

Woodwinds Health Campus

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APPENDIX D



Minnesota Department of **Human Services**

Adult Mental Health

ACT/IRT Services

Definition of ACT:

Assertive Community Treatment (ACT) is provided by multidisciplinary treatment teams with a low client to case manager ratio (10-1). Services can be provided wherever the person needs them. This service is targeted to persons who have the most serious mental illnesses and who have not benefited from conventional community care. Characteristics of ACT are shared caseloads among clinicians (rather than individual caseloads); direct provision of services, rather than brokering services to other providers; 24-hour coverage, including emergencies; close attention to illness management; most services provided in the community, rather than at the clinic; high frequency of contact with clients; and assistance with practical problems in living.

Date of ACT Implementation: January 2005

Current Number of Teams: 26

Definition of IRTS:

Intensive Residential Treatment Services (IRTS) Programs are governed by M.S. 256B.0622, M.S.245.472 and Minnesota Rules 9520.0500 to 9520.0690. These are short-term, time-limited services provided in a residential setting to recipients who are in need of this level of supervision and treatment and are at risk of significant functional deterioration if they do not receive these services. People may benefit from this level of service following acute hospitalization, or as a deterrent to it. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must focus upon supporting recovery through the use of established rehabilitative principles and evidence based practices. Services must be directed toward a targeted discharge date with specified client outcomes.

Date of IRTS Implementation: October 2004

Current Number of Teams: 32

Futuristic IRTS Teams Currently Being Developed:

Type	County/Name
IRTS	Hennepin / Correctional
IRTS	Hennepin / Ramsey Tertiary Care
IRTS	Wright

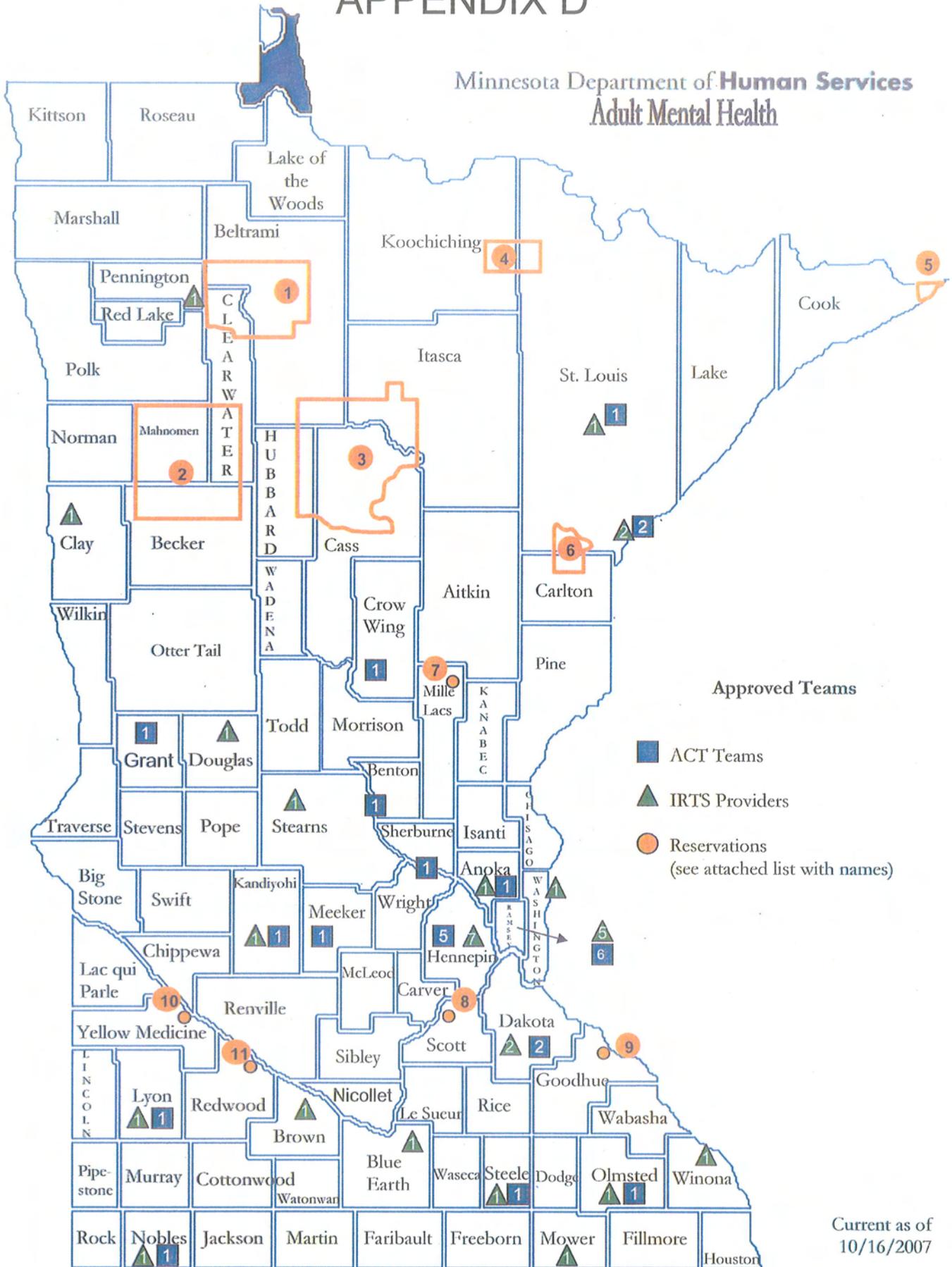
Reservations in Minnesota:

1. Red Lake
2. White Earth
3. Leech Lake
4. Bois Forte / Nett Lake
5. Grand Portage
6. Fond du Lac
7. Mille Lacs
8. Shakopee Mdewakanton Sioux
9. Prairie Island
10. Upper Sioux
11. Lower Sioux

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APPENDIX D

Minnesota Department of Human Services Adult Mental Health



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Minnesota Department of **Human Services**

Adult Mental Health

ARMHS Services

Definition of ARMHS:

Adult Rehabilitative Mental Health Services (ARMHS) is a Medicaid (MA) funding stream permitting rehabilitation services to be provided one-to-one or in groups, within the home or in the community by qualified staff.

ARMHS means mental health services enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. ARMHS are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional de-compensation or more restrictive service settings without these services.

ARMHS instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

Primary certification determines if the applicant provider entity meets the standards, criteria, assurances, and requirements to be certified as a provider entity of ARMHS, as listed in the legislation. A primary certification can be given to a county (by DHS) or to a non-county provider applying through a county.

Local certification is obtained by an entity already having a primary certification. They can seek "local" certification to provide services in other counties. Receiving local certification requires that the provider be knowledgeable of the local county's health and human service resources.

History of Dates of Implementation/Operation:

ARMHS began March 15, 2002 with five providers. As of May 7, 2007, there are currently 111 providers providing services in all 87 counties.

ON THIS MAP:

ARMHS is offered in all 87 counties in Minnesota. For the purpose of this map, we are showing only the Primary certifications or the counties where a provider entity is actually located. The number inside each shape indicates the number of providers in that county. ***If a county doesn't have anything in it, assume that a provider is offering local ARMHS in that county.

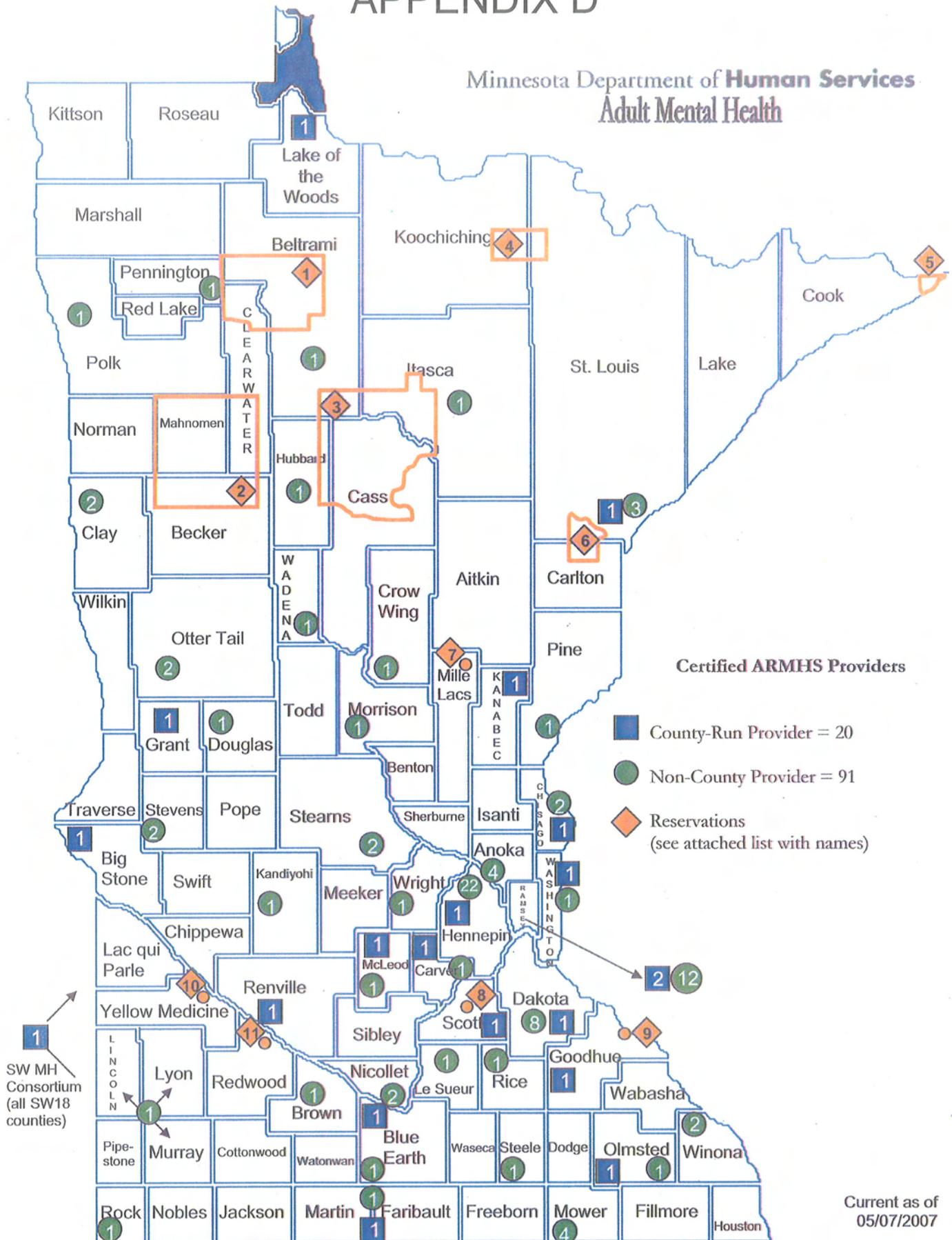
Reservations in Minnesota:

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| 2. White Earth | 8. Shakopee Mdewakanton Sioux |
| 3. Leech Lake | 9. Prairie Island |
| 4. Bois Forte / Nett Lake | 10. Upper Sioux |
| 5. Grand Portage | 11. Lower Sioux |
| 6. Fond du Lac | |

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Minnesota Department of **Human Services** Adult Mental Health



APPENDIX D



Minnesota Department of Human Services

Adult Mental Health

MA Crisis Response Services

Definition of Crisis Services:

These are MA services targeted to respond to needs of people experiencing a mental health crisis or mental health emergency (see Minnesota Statutes, section 256B.0624, subd. 2. (a) and (b)); and in some cases this will include short-term needs following intervention. These services are intended to assist the recipient to regain functioning to the level of functioning prior to the crisis/emergency or to refer to longer-term supports that will assist the recipient in regaining functioning; to diminish crisis/emergency-related suffering of the recipient; to avoid, where possible, more restrictive service settings; and to maintain community living by the recipient. The services include: crisis assessment, crisis intervention, crisis stabilization (in community and short-term residential), and community intervention.

History of Dates of Implementation/Operation:

The Crisis Services began operating January 1, 2003. Crisis Services operate on a contract model. As of May 7, 2007, there are currently 28 crisis providers providing services in 31 counties. As 2007 continues, we expect to see an increase of additional providers as many of the contracts are up for renewal.

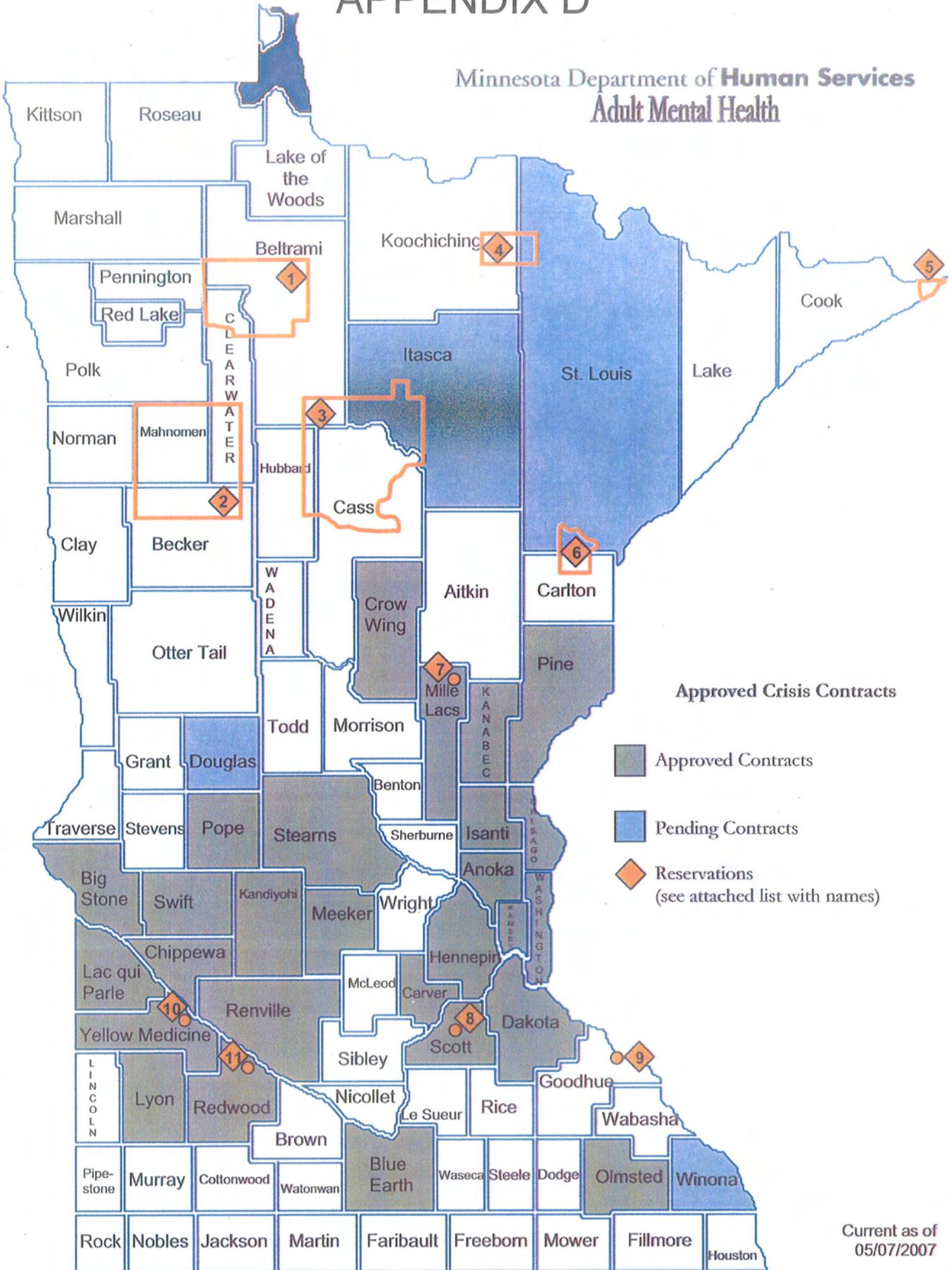
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Minnesota Department of Human Services Adult Mental Health



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Minnesota Department of **Human Services**

Adult Mental Health

Community Based Extended Psychiatric Hospital Beds

There are two types of contracts; both having a goal of providing statewide availability of extended psychiatric inpatient services for recipients of MA, individuals dually eligible under MA and Medicare, and uninsured individuals.

Definition of Medical Assistance (MA) Contracts:

The MA contract covers MA fee for service recipients. Funding under the MA contract is for MA eligible adults meeting all of the criteria in # 1 - 6 and one of the criteria in #7:

1. age 18 years or older, or attaining 18 years within 45 days of admission, or upon notice of the State during the medically necessary length of stay covered under the contracts, which ever standard is in effect at the time of the patient episode;
2. not under a 72-hour or court ordered hold;
3. not in a prepaid health plan;
4. not dually eligible for MA and Medicare, unless the patient has exhausted Medicare inpatient psychiatric benefits;
5. persons whose county of financial responsibility is in Minnesota, unless otherwise approved by DHS;
6. persons who need psychiatric inpatient services beyond what is normally available under the MA diagnostic-related (DRG) payment; and
7. the need for psychiatric inpatient services must be documented in at least one of the following ways:
 - a. a judicial commitment under Minnesota Statutes, Chapter 253B as mentally ill;
 - b. a revocation of a provisional discharge;
 - c. a stayed commitment; or
 - d. a voluntary hospitalization: there must be clear documentation by the attending physician in the patient's hospital record that continued psychiatric inpatient hospitalization is needed for treatment completion, and the patient is capable of giving informed consent for voluntary treatment or has a substitute decision maker who will consent to the treatment. The attending physician must determine if a voluntary hospitalization is appropriate, and that it is consistent with the definition of medically necessary care in Minnesota Statutes 62Q.53, Subd.2. the hospital must work in consultation with the county, to the extent that the patient consents, to determine if there are less restrictive alternatives available.
 - e. a continuance of a commitment proceeding, with inpatient services stipulated as part of the condition of the continuance.

Definition of Subsidy Grant Contract Bed Hospitals:

The subsidy grant contract covers uninsured and underinsured individuals who do not qualify under the MA contract.

The criteria for coverage under the subsidy grant contract is the same as above, except:

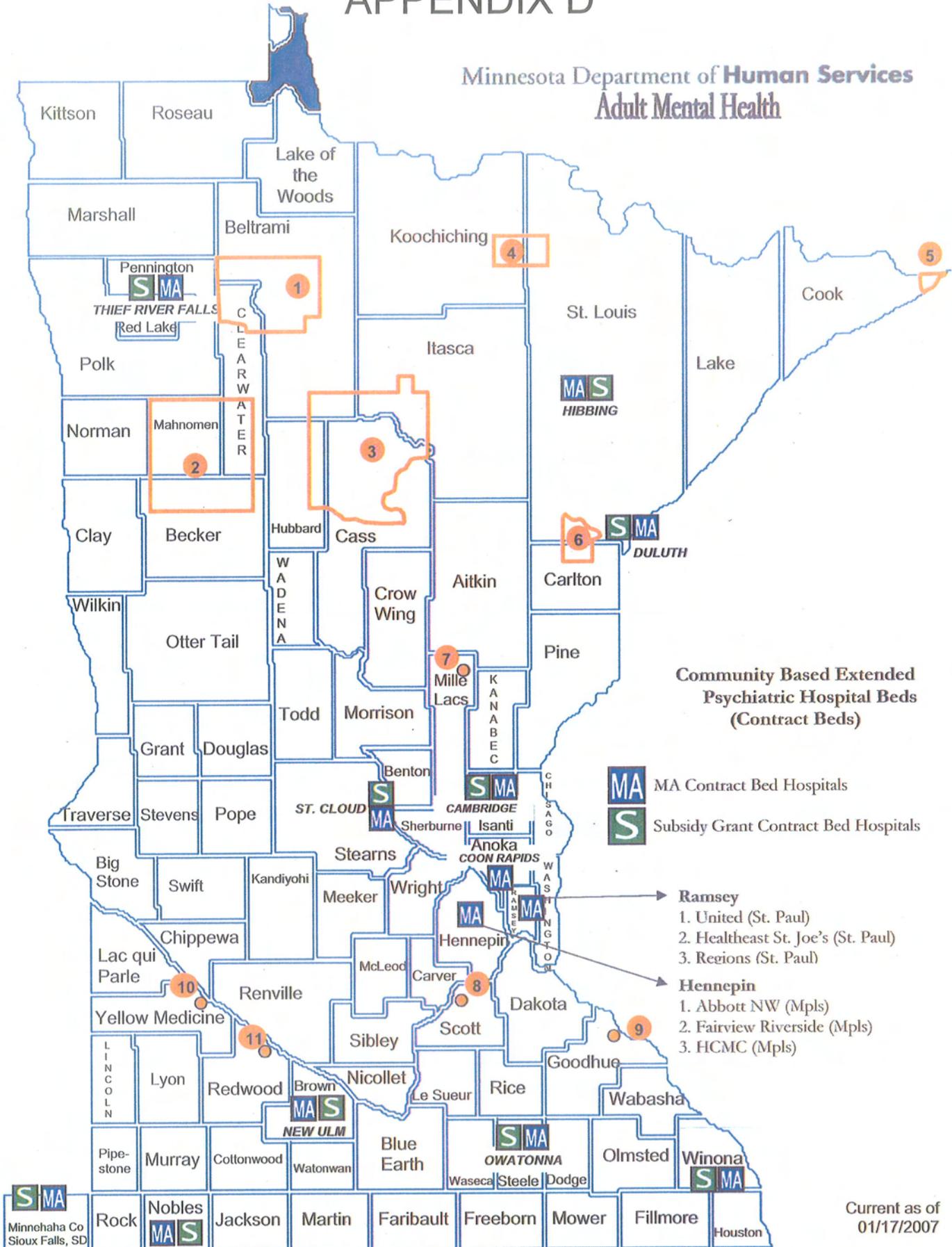
- a. Recipient cannot be covered under the MA contract; and
- b. Recipient county of financial responsibility is any Minnesota County, except the 7-county metro area (Anoka, Hennepin, Carver, Scott, Ramsey, Washington, and Dakota Counties).

Reservations in Minnesota:

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Minnesota Department of Human Services

Adult Mental Health

CADI Slots

Definition of CADI:

Community Alternatives for Disabled Individuals (CADI) is a comprehensive package of Medical Assistance services, which can be used to provide care and support for people to live in their own home, instead of in a nursing home.

To be eligible for CADI, the person must:

- Be eligible for MA as a person with a disability
- Require the level of care provided in a NF
- Have a community care plan that reasonably assures health and safety
- Be able to have CADI services provided within the waiver's funding limits

CADI services are provided to approximately 9,000 individuals in MN annually. The service is provided to persons with a wide range of diagnoses. At present, there are 3,030 adult persons with a primary diagnosis of mental illness using a CADI waiver. This is represented by the **small sized numbers** in each county.

As part of the MH restructuring efforts, we have also allocated CADI capacity for those individuals needing the level of service available at Ah Gwah Ching. The **large sized numbers** in each planning region represent this, depicting 69 statewide.

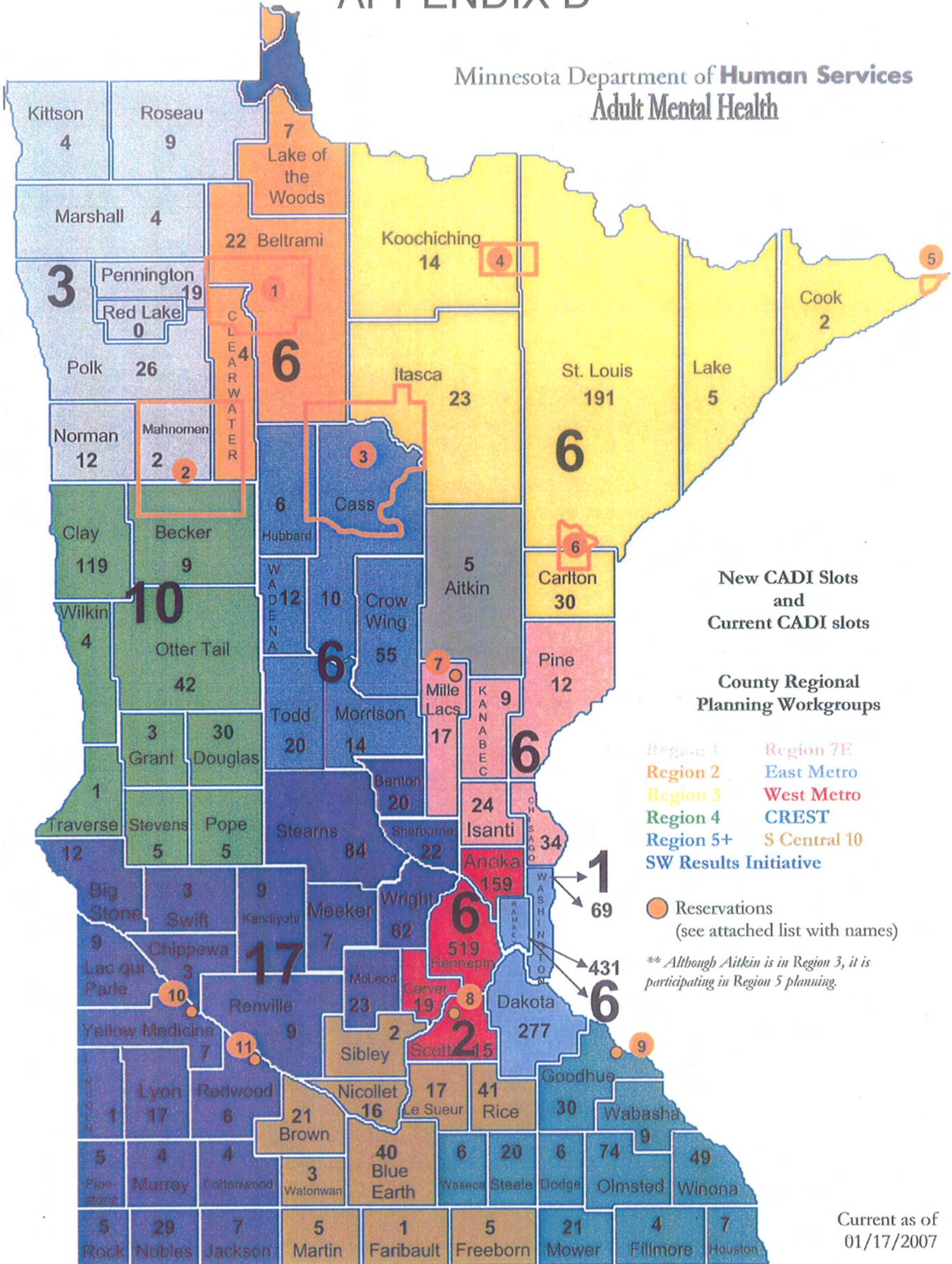
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Minnesota Department of **Human Services**

Community behavioral health hospitals: Complementing a new array of mental health services

Beginning in 2006, State Operated Services, the area of the Minnesota Department of Human Services that provides direct services to people with disabilities, will begin operating several widely dispersed 16-bed psychiatric hospitals called community behavioral health hospitals. These hospitals will provide acute psychiatric inpatient care for adults. Development of the new hospitals is part of a redesign of mental health services in Minnesota.

Treatment will use evidence-based practices, which are methods of treatment that research has demonstrated are effective in supporting people with mental illness in their recovery. SOS has been asked to operate these hospitals by regional planning work groups, which have been collaborating over the past several years to build adult mental health treatment capacity in smaller settings, closer to individuals' communities, homes, and natural supports of family and friends. Along with an array of other community-based mental health services, the hospitals are replacing inpatient adult mental health services previously provided on regional treatment center campuses.

People served

The hospitals will serve adults with mental illness who need an acute psychiatric hospital level of care in a safe environment. The goal is to serve patients as close as possible to their home communities in either the community behavioral health hospitals or community hospital psychiatric units. The community behavioral health hospitals will not serve people civilly committed as mentally ill and dangerous, a sexually dangerous person or as a person with a sexual psychopathic personality.

Treatment services

The hospitals will provide intensive, multidisciplinary services, including:

- Assessment of mental, social, and physical health by physicians, psychiatrists, clinical nurse specialists, advanced practice nurses, psychologists, clinical social workers and other rehabilitation therapists, as appropriate. (The hospitals will not provide emergency medical services. Therefore, patients referred to a community behavioral health hospital must have their medical stability assured before admission. This stability is commonly assessed within a community hospital emergency room or another acute care physical medicine setting.)
- Development of an individual treatment plan, including medication management and 24-hour nursing care
- Active mental health treatment and programming, including the integration of important aspects of the Illness Management and Recovery model of care; this model is an individualized, person-centered approach that includes the family and community in treatment planning and implementation
- Individualized discharge planning and collaboration with patients, family members, significant others as well as county social services and mental health case managers for transitioning back to an appropriate setting in the community.

APPENDIX D

Staffing

Each community behavioral health hospital will be staffed 24 hours a day. The hospitals will employ about 30 staff, including mental health professionals specializing in psychiatry, nursing, psychology and social work.

Referrals/admissions

Referral sources will include county social service agencies, the courts, local mental health providers, community hospitals and private mental health practitioners. Referrals for admissions will be processed through a centralized preadmission center, staffed on a round-the-clock basis. Law enforcement, courts, other providers and social service organizations looking for admissions into these facilities will be able to call a centralized toll-free number. Staff there will assess the individual admission and determine the most appropriate placement considering the individual's needs, home community location and natural support system.

Locations

SOS will operate community behavioral health hospitals in Alexandria, Annandale, Bemidji, Baxter, Cold Spring, Eveleth, Fergus Falls, Rochester, St. Peter and Wadena. [Maps of public adult mental health providers in Minnesota](#) are on DHS' Web site.

Other community-based services

Community behavioral health hospitals will be an important part of the array of mental health treatments supported by research, including:

- Adult Rehabilitative Mental Health Services, which instruct, assist, and support individuals in such areas as relapse prevention, transportation, illness management and life skills
- Assertive Community Treatment teams, which serve as "hospitals without walls," providing intensive, round-the-clock supports to people with serious mental illness in their homes, at work and elsewhere in the community by multidisciplinary treatment teams
- Crisis response, from mobile crisis teams to short-term crisis stabilization beds
- Intensive Residential Treatment Services, with up to 16 beds, which provide short-term, intensive 24/7 mental health treatment in small community-based settings
- Outpatient treatment
- A variety of additional support services that help people with mental illness work and manage various activities of daily life.

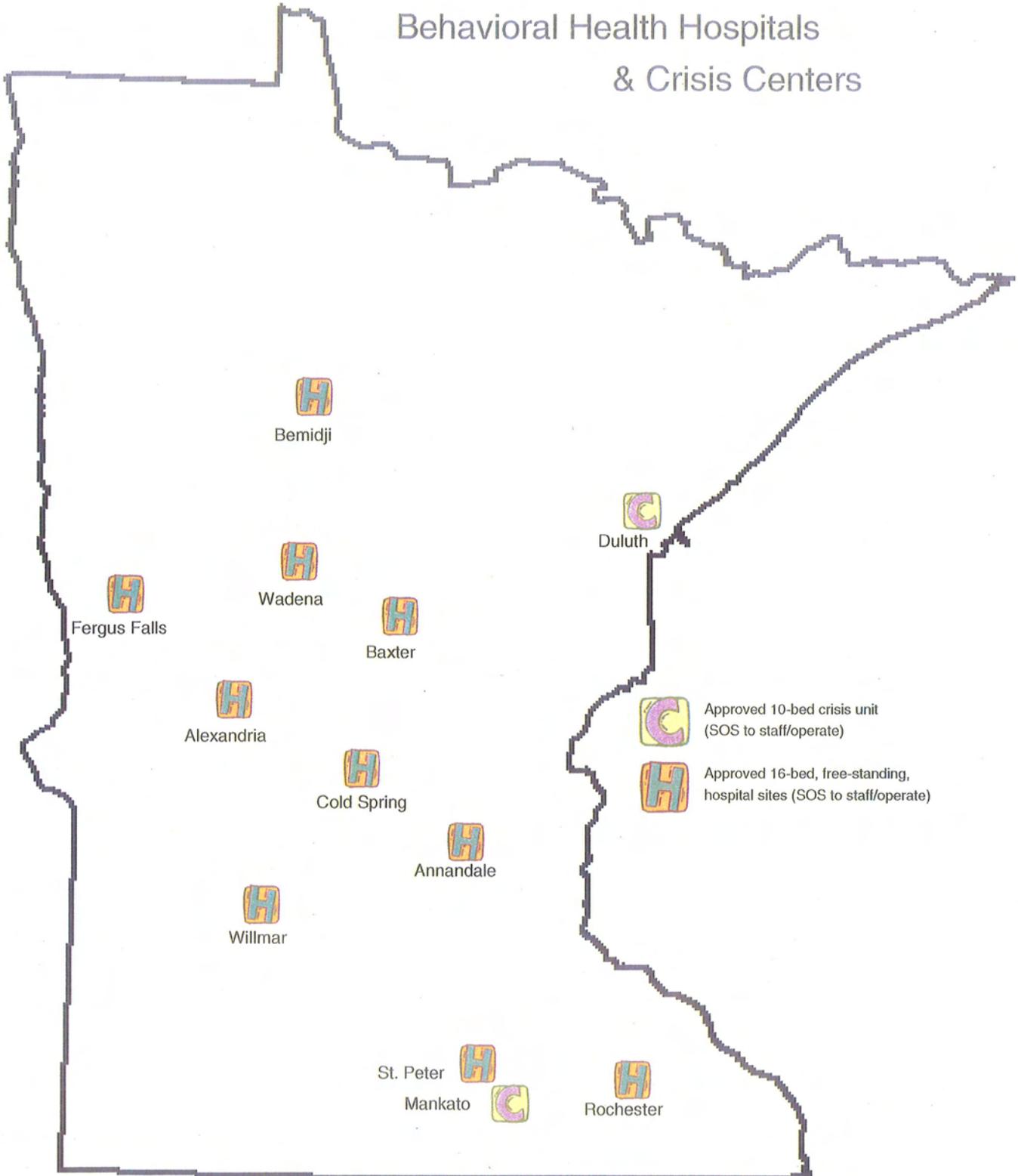


Architect's rendering of Community Behavioral Health Hospital-Alexandria, courtesy of Cole Group Architects, St. Cloud

August 2006

APPENDIX D

State-Operated Community-Based Behavioral Health Hospitals & Crisis Centers



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Hospital Name	Hospital County	Hospital Region	Available		Psychiatric		Psychiatric		MH		Occupancy		
			Psych Beds	1995	2004	Admits	2005	Patient Days	2005	MH		%	
										ALOS	2005	ALOS	2005
Cambridge Medical Center	ISANTI	TC MSA	12	14	14	164	588	4,761	8.8	8.1	32.9%	93.2%	
Mercy Hospital	ANOKA	TC MSA	34	32	32	873	1,410	8,144	9.3	6.4	65.6%	77.4%	
Regina Medical Center	DAKOTA	TC MSA	0	10	10	189	1,890	1,890	10.0	10.0	51.8%	51.8%	
Fairview Southdale Hospital	HENNEPIN	TC MSA	18	16	16	409	907	3,814	4.8	5.3	58.1%	83.1%	
Abbott Northwestern Hospital	HENNEPIN	TC MSA	95	93	93	3,314	3,404	24,277	7.3	7.1	70.0%	70.8%	
Fairview Riverside Medical Center	HENNEPIN	TC MSA	179	Closed	Closed	3,829	Closed	38,556	10.1	Not open	59.0%	Closed	
Fairview-University Medical Center	HENNEPIN	TC MSA	0	171	171	Not open	4,130	39,600	Not open	9.6	Not open	63.4%	
Hennepin County Medical Center	HENNEPIN	TC MSA	88	84	84	1,945	1,949	25,680	13.2	15.7	80.0%	99.5%	
University of MN Hospital & Clinic	HENNEPIN	TC MSA	58	Closed	Closed	1,077	Closed	14,319	13.3	Closed	67.6%	Closed	
North Memorial Medical Center	HENNEPIN	TC MSA	26	26	26	0	1,177	7,628	6.5	6.5	69.7%	80.4%	
Regions Hospital	RAMSEY	TC MSA	67	80	80	2,208	2,739	21,550	9.8	10.1	88.1%	95.2%	
St. Joseph's Hospital	RAMSEY	TC MSA	46	36	36	690	1,354	5,777	8.4	7.7	34.4%	79.0%	
United Hospital	RAMSEY	TC MSA	45	59	59	1,358	1,971	9,890	7.3	8.7	60.2%	79.6%	
Twin Cities MSA Total			668	621	621	15,867	19,818	177,620	10.1	9.9	65.6%	76.4%	
Miller-Dwan Medical Center	ST. LOUIS	Other MSA	54	53	53	1,137	2,616	8,782	15.246	7.7	5.8	44.6%	78.8%
St. Luke's Hospital	ST. LOUIS	Other MSA	29	22	22	584	900	3,523	4.103	6.0	4.6	33.3%	51.1%
Fairview University Medical Center - Mesabi	ST. LOUIS	Other MSA	14	21	21	397	631	2,647	5,720	6.7	6.9	51.8%	74.6%
Mayo Psychiatry and Psychology Treatment	OLMSTED	Other MSA	79	74	74	1,821	2,600	9,217	19,935	5.1	7.7	32.0%	73.8%
St. Cloud Hospital	STEARNS	Other MSA	33	34	34	966	1,619	5,758	6.863	6.0	4.2	47.8%	55.3%
Other MSAs Total			209	204	204	4,905	8,566	29,927	6.1	6.1	39.2%	69.7%	
North Country Health Services	BELTRAMI	Metropolitan	0	12	12	203	203	2,341	11.5	11.5	53.4%	53.4%	
Immanuel St. Joseph's - Mayo Health System	BLUE EARTH	Metropolitan	32	18	18	473	591	3,877	2,821	8.2	4.8	33.2%	42.9%
New Ulm Medical Center	BROWN	Metropolitan	5	10	10	175	377	1,094	2,036	6.3	5.4	59.9%	55.8%
Hutchinson Area Health Care	MCLEOD	Metropolitan	12	12	12	646	646	1,958	3,613	4.2	5.6	44.7%	82.5%
St. Joseph's Medical Center	CROW WING	Metropolitan	22	22	22	429	697	4,748	7.8	6.8	41.5%	59.1%	
Austin Medical Center - Mayo Health System	MOWER	Metropolitan	12	12	12	353	353	2,481	7.0	7.0	0.0%	56.6%	
District One Hospital	RICE	Metropolitan	4	0	0	99	99	564	5.7	5.7	38.6%	38.6%	
Owatonna Hospital	STEELE	Metropolitan	10	10	10	175	317	1,579	2,298	9.0	7.2	43.3%	65.0%
Community Memorial Hospital	WINONA	Metropolitan	12	10	10	182	416	1,106	1,677	6.1	4.0	25.3%	45.9%
Rice Memorial Hospital	KANDIYOHI	Metropolitan	12	12	12	236	245	1,542	1,512	6.5	6.2	35.2%	34.5%
Worthington Regional Hospital	NOBLES	Metropolitan	10	10	10	239	217	1,399	1,271	5.9	5.9	38.3%	34.8%
Lake Region Healthcare Corporation	OTTER TAIL	Metropolitan	8	14	14	130	344	1,110	2,401	8.5	7.0	38.0%	47.0%
Metropolitan Areas Total			139	142	142	2,607	4,406	17,566	6.7	6.2	34.5%	52.6%	
Grand Itasca Clinic and Hospital & C&C	ITASCA	Rural	11	0	0	80	80	657	11.4	11.4	16.4%	16.4%	
Meeker County Memorial Hospital	MEEKER	Rural	15	8	8	342	407	1,934	5.7	6.0	35.3%	56.1%	
Northwest Medical Center	PENNINGTON	Rural	26	20	20	422	548	2,591	6.1	7.4	27.3%	55.7%	
Rural Areas Total			26	20	20	422	548	4,068	6.1	7.4	27.3%	55.7%	
Brainerd Regional Human Services Center	CROW WING	Metropolitan	135	144	144	383	107	33,916	86.6	72.9	68.8%	14.8%	
Anoka Metro Regional Treatment Center	ANOKA	TC MSA	247	200	200	444	849	87,853	197.9	106.0	97.4%	123.3%	
Eveleth Behavioral Health State Operated Svc	ST. LOUIS	Other MSA	16	16	16	82	82	3,596	43.9	43.9	0.0%	61.6%	
Fergus Falls Regional Treatment Center	OTTER TAIL	Metropolitan	115	50	50	448	66	40,637	2,705	90.7	41.0	96.8%	14.8%
Wilmar Regional Treatment Center	KANDIYOHI	Metropolitan	305	127	127	961	287	93,781	15,809	97.6	55.1	84.2%	34.1%
St. Peter Regional Treatment Center	NICOLLET	Metropolitan	176	38	38	517	38	58,451	2,339	113.1	61.6	91.0%	16.9%
State-Operated Statewide TOTAL		Statewide	894	575	575	2,753	1,429	31,493	114.3	85.6	95.7%	58.3%	
Community and State-Operated TOTAL		Statewide	2,036	1,662	1,662	26,564	34,767	624,777	19.8	11.0	70.6%	67.2%	

Notes:
 Hospital admissions included residents of other states.
 MN residents' admission to hospitals in other states not included.
 Some hospitals did not report.
 Source: MDH Health Care Cost Information System

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APPENDIX F



Office of the Sheriff

Anoka County
Sheriff Bruce Andersohn

325 East Main Street, Anoka, MN 55303-2489 (763)323-5000 Fax (763)422-7503

DATE: *Monday, June 4th, 2007*

TO: *Capt. Small*

FROM: *E*
Sgt. Herschberger

SUBJECT: *Costs Associated with Civil Commitment Transports*

All of the statistics on the attached pages are taken directly from the daily transport logs completed by Anoka County Sheriff's Office Transport Deputies, with one exception.

The numbers associated with "phone calls" was based on a very conservative estimate. Each Monday, Wednesday, and Thursday, staff in the Transport Unit must go through each order and call each facility from which each patient is to be transported the following day. In addition to giving the facility an estimated time of arrival of the transport deputies, the Sheriff's Office staff must determine if the patient has any problems:

- medical conditions which would prevent normal Sheriff's Office Transport,
- walking, standing, and/or sitting conditions that would prevent normal Sheriff's Office Transport,
- behavior or other "risk" factors that Deputies should be aware of.

If complications arise, the staff making the calls must deal with that problem. Sometimes "the problem" means making arrangements for an ambulance to do the transport. Other times it requires calls to the social worker for additional info. Often, it takes a lot of contact time with facilities to get to a nurse who can provide truly accurate information. The phone calls require writing a memo so the deputies who conduct the transport the following day have the info they need.

I would estimate that on Mondays and Wednesdays, phone calls involve at least ½ hour each on the two days. With the smaller number of hearings scheduled on Fridays, I estimated that would be about 15 minutes for Thursday's phone calls. By taking 1 ¼ hours times 52 weeks a year, this involves a sum of 65 hours. (This doesn't account for phone calls related to the transfers of patients from one facility to another.)

The total number of transports, both for court and transfers, are statistics we have normally tracked and the numbers come from our monthly reports. The time commitment & mileage statistics were derived by having a staff person hand count each transport log each day for the



APPENDIX F

two years we reviewed. We had to do it this way because we have never divided these categories for our normal tracking purposes. They are accurate numbers, but don't appear on our monthly report broken out in these categories. The number of Jail Division lunches provided by the Sheriff's Office for patients are also numbers we have specifically tracked and accounted for, beginning in 2006.

Also please note there is a great deal of transport work that has to be scheduled for late in the day. This is due to court appearances being "time sensitive" and required to be completed based on the transport order. Most of the transports related to criminal cases, warrants, writs, prison commits have to be put off until late in the day. Those transports, if tracked specifically, would reflect much of our overtime costs. But only because they get pushed off until later in the day.

The attached data and cost analysis shows an accurate, but very conservative amount of expenses absorbed by the Sheriff's Office.

If you have any questions, please contact me.

:EH

APPENDIX F



<u>TOTAL EXPENSES RELATED TO CIVIL</u>		
<u>COMMITMENT TRANSPORTS 2006</u>		
Deputy Hours In Transit	Regular: 1,734.5 Overtime: 388	\$62,130 and \$18,099
Miles Driven	35,419	\$17,178
Monitoring Hours	744	\$26,650
Telephone Hours	65	\$2,328
Lunches Provided to Patients	122 bag lunches from Jail x \$1.40 each and 1 fast food drive-thru @ \$3.41	\$170.80 and \$3.41
GRAND TOTAL*		\$126,559.21

*See Memo of Explanation

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STATISTICS ASSOCIATED
WITH
CIVIL COMMITMENT TRANSPORTS
2006

	Deputy Hours in Transit	Miles Driven	Hours Monitoring Patients	Court Hearings	Transfers
January	122.5	1697	63	88	9
February	202	3456	77	90	8
March	144	2259	54	84	4
April	186.5	3355	57	71	5
May	107	1547	63	82	16
June	113.5	1768	69	93	15
July	210	3528	61	73	15
August	217	3227	66	144	12
September	145.5	2029	38	75	12
October	180.5	3283	51	86	12
November	242.5	4407	72	95	14
December	251.5	4863	73	96	3
Grand Total	2,122.5 hours	35,419 miles	744 hours	1,077 transports	125 transfers

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STATISTICS ASSOCIATED
WITH
CIVIL COMMITMENT TRANSPORTS
2005

	Deputy Hours in Transit	Miles Driven	Hours Monitoring Patients	Court Hearings	Transfers
January	134	2288	57	71	4
February	177	3046	62	53	9
March	212	3710	61	102	14
April	157	2619	80	108	1
May	157	2409	68	105	7
June	202	3787	86	125	10
July	171.5	3152	67.5	80	13
August	156.5	2570	41	75	11
September	208.5	3970	68	84	9
October	233.5	4272	79	107	10
November	105.5	1379	59.5	54	14
December	165	2731	60	87	3
Grand Total	2,079.5 hours	35,933 miles	789 hours	1,051 transports	105 transfers

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APPENDIX G

EMS Transport of Behavioral Health Patients: *Frequently Asked Questions* (June 2007)

- 1) Is a Minnesota licensed ambulance service required to accept a request for inter-facility transport of a behavioral health patient from one health facility to another where a psychiatric bed has been located?

Answer: **Minnesota Statutes, section 144E.101, subd. 3**, requires licensed ambulance services to provide continual service 24 hours a day, every day of the year (except for authorized specialized and part-time ALS services). However, it is understood that there will be times when an ambulance service's resources may be stretched and they will have to rely on mutual aid for assistance. The ambulance service should staff at a level necessary to cover their primary service area (PSA) under normal circumstances. An ambulance service should not **routinely** deny such requests, except in the following circumstances: 1) when there is another ambulance service that holds a specialized license for inter-facility transports in the same PSA that is capable of handling the transport; or 2) in the case of a low-volume ambulance service where only one staffed truck adequately covers the PSA. (Low volume ambulance services with a single ambulance must be cautious about accepting non-emergency, inter-facility transports when it will leave their PSA without coverage for 911 calls for an extended period of time.)

- 2) Question: Is an ambulance service required to transport a patient from one health facility to another when there is no "medical necessity" for using the ambulance?

Answer: **Minnesota Statutes, sec. 144E.01, subd. 3** defines ambulance service as: "transportation and treatment which is rendered or offered to be rendered preliminary to or during transportation to, from, or between health care facilities, for ill or injured persons or expectant mothers. The term includes all transportation involving the use of a stretcher, unless the person to be transported is not likely to require medical treatment during the course of transport."

There will be times when it appears likely that the person will not require medical treatment during transport to a psychiatric facility. Often that person can be transported by private vehicle or otherwise, e.g., law enforcement. The determination if there is medical necessity for transport by ambulance is typically made by the physician or mental health practitioner who has evaluated the person at the requesting facility.