

**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**



Special Senate Commission to Study  
Rhode Island Emergency Department  
Room Diversion

**Findings and Recommendations**

Report Submitted to the  
Rhode Island State Senate

**February 16, 2012**

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TO STUDY EMERGENCY DEPARTMENT DIVERSION**

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Special Senate Commission to Study Rhode Island Emergency Room  
Diversion

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**Rhode Island Senate**  
Special Commission to Study Rhode Island  
Emergency Department Room Diversion

**W**e are pleased to present these findings and recommendations of the Special Senate Commission to Study Emergency Department Diversion. This report represents the best thinking of a distinguished and dedicated Commission whose membership consists of elected officials, health insurance providers, large affiliated hospitals, smaller community hospitals, healthcare professionals, and experts from throughout Rhode Island. Over the course of several hearings, Commission members heard informed testimony, examined current challenges facing the state's healthcare system, reviewed best practices, and considered the most reasonable and effective means to reduce and contain costs, improve efficiencies, and increase patient centered care for individuals struggling with behavioral health and substance use disorders.

Our study found that our emergency departments serve a critical function in Rhode Island, yet the system is faced with an over utilization of high cost resulting in high levels of non-urgent behavioral health usage that could be more effectively treated in alternative settings. We further found that municipalities face significant costs and personnel stressors for transporting individuals with non urgent behavioral health and/or substance use disorders to emergency room departments; patients and providers face significant treatment access issues: patient obstacles; third party limitations; budget and resource limitations; that our delivery system is fragmented- for individuals with behavioral health and/or substance use disorders lacking a continuum of comprehensive, integrated emergency services and there are demonstrated models that provide quality care for individuals with behavioral health and/or substance use disorders outside of hospital emergency departments

We are grateful to every member of the Commission for their willingness to take part in these discussions and appreciate the many experts who took time to appear before the Commission and

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contributed to our understanding of the challenges and opportunities facing Rhode Island's hospital system.

As per the requirements of 2011 Senate Bill 875 Substitution A, we offer these findings and recommendations with confidence that we can help improve efficiencies, deliver better patient centered coordinated systems of care and achieve cost savings for government entities, insurers, hospitals and providers.

Sincerely,

**Co-Chairman Senator Paul V. Jabour**  
District 05- Providence

**Co-Chairman Senator Joshua Miller**  
District 28- Cranston, Warwick

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**Executive Summary**

On May 25, 2011, Senate Bill 0875 Substitute A was read and passed by the Rhode Island Senate creating the Senate Commission to Study Rhode Island Emergency Department Room Diversion. The Commission, co-chaired by Senators Paul V. Jabour (District-05, Providence) and Joshua Miller (District 28, Cranston, Warwick) were authorized to study:

- The issue of emergency room diversions for individuals with substance abuse disorders;
- The trends, current policies, and data pertaining to Rhode Island hospitals emergency department utilization and emergency department diversion;
- The regulatory restrictions which currently prevent Rhode Island emergency diversion initiatives;
- The current models that are being used by other states or municipalities to mitigate the problem;
- The ways to remedy gaps in alternatives, specifically in the area of making provisions for their availability and use; and,
- Identify permanent funding options for emergency department alternatives facilities.

The Commission met five times over the past three months: November 9, 2011; November 23, 2011, December 14, 2011; January 11, 2012 and January 25, 2-12 and was charged with presenting its findings and recommendations to the Senate on or before January 31, 2012. This document represents the final report of the Special Senate Commission.

While the Commission process was cooperative and collaborative, with outstanding input and support from all parties, there was not unanimous consent for all of the findings and recommendations included in this report. Each member was provided the opportunity to express support, objection, or offer alternatives, to each finding and recommendations directly in the report.

As described in this document, the Commission's findings are summarized as follows:

- Our emergency departments currently face an over utilization of high cost, high levels of non urgent substance disorder and/or behavioral health usage that could be treated more effectively in alternative settings.
- Our municipalities face significant costs and personnel stressors for transporting individuals with non urgent behavioral health and/or substance use disorders to emergency room departments.

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- Our patients and providers face significant treatment access issues: patient obstacles; third party limitations; budget and resource limitations.
- Our state system currently provides funding for alternative stabilization units for those diagnosed with psychiatric disorders but limits eligibility criteria through regulations, significantly reducing access for those with active substance use disorders in need of services.
- Current Department of Health state ambulance advisory council protocols for individuals with behavioral health and/or substance use disorders prevent Emergency Medical Technicians from transporting individuals to settings other than an emergency department.
- Coordination among healthcare providers and the delivery system is fragmented- for individuals with behavioral health and/or substance use disorders lacking a continuum of comprehensive, integrated emergency services.
- Nationally, there are demonstrated models that provide quality care for individuals with behavioral health and/or substance use disorders outside of hospital emergency departments that document improved health outcomes.

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As described in this document, the Commission's recommendations are as follows:

- Amend the existing RI alcohol statute for a pilot period to make it more flexible
  
- Create state- wide care partnerships to enhance patient- centered systems of care to include on-demand services, 24 hour triage center programs, mobile outreach transportation teams, and telephone triage systems
  
- Support opportunities with Community Mental Health Organizations through Health Homes Medicaid enhanced funding, to include person centered alternative settings to emergency departments
  
- Support the state wide coordination and implementation of an evidence based suicide/ mental health assessment tool and training for Rhode Island healthcare providers and first responders.
  
- Support the development of a pilot program proposal and protocols for Emergency Management Services (EMS) transports to alternative facilities.
  
- Support opportunities to enhance or reinvest savings for best practice housing models that include supportive services and employment/ training linkages.
  
- Support the department of behavioral healthcare developmental disabilities and hospitals in exploring opportunities for funding the alternative pilot program.



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**Introduction**

Our hospital emergency room departments serve a critical function- open 24 hours a day, 7 days a week- these entities are a major part of our nation's health care safety net. Of the estimated 119 million visits to U.S. emergency departments in 2006, over 40 percent were paid for by federally-supported programs.<sup>1</sup>

In 2010, the General Assembly created the *Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals*. The Commission represented the best thinking of distinguished and dedicated members who made a series of recommendations including that the state's overreliance on costly, and sometimes unnecessary hospital emergency room visits for behavioral health evaluations and developed recommendation number nine that specified a need to create more behavioral health interventions.

As a result of this recommendation, in 2011 the Senate passed resolution S875 which created a Special Commission to Study Emergency Department Diversion. The commission brought together experts in the field and those on the front lines, consisting of department directors, medical professionals, CEOs, insurance providers and first responders. The members examined current research and data of non emergent ED usage, alternatives and opportunities.

Throughout the course of the presentations and first hearing there was commonality and agreement among all member that included several themes:

- our system's failure to appropriately and cost effectively treat individuals with non emergent behavioral health issues;
- the devastating impact to both the individual and the system when budgets cuts undermine services provision; and

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<sup>1</sup> S. R. Pitts, R. W. Niska, J. Xu, and C. W. Burt, "National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary," *National Health Statistics Reports*, no. 7 (2008).

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- the importance of examining and changing laws that prevent alternatives to screening and treating non emergent behavioral health issues in locations other than the emergency department.

Continuing to utilize the emergency room department for individuals with substance use disorders for non emergent medical needs is not only a system failure but also a failure to the individual as well. There are better alternatives and more effective approaches that can be utilized but only if we make a commitment to changing our current system of care. Additionally, by delivering supportive, comprehensive services that provide a continuum of care for substance use disorders and/ or behavioral health issues have been proven to decrease readmissions to emergency room departments.

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**Special Senate Commission to Study Rhode Island Emergency  
Department Room Diversion**

**Timeline**

November 9, 2011 – Senate Lounge, State House

- Presentation and findings
- Presenters: Hospital panel participants, Neighborhood Health Plan and Department of Human Services

November 30, 2011 - Senate Lounge, State House

- First responders and provider needs for chronic behavioral health issues
- Presenters: Commissioner Pare, Providence , Detective Jackson, Pawtucket, Neighborhood Health Plan and Department of Human Services

December 14, 2011 – Senate Lounge, State House

- Current regulations, considerations and potential models
- Presenters: Jason Rhoades, HEALTH, Director Stenning, Behavioral Healthcare, Developmental Disabilities and Hospitals and Dale Klatzker, the Providence Center

January 11, 2012 – Senate Lounge, State House

- Presenter: Wilfred Labiosa, Executive Director Cambridge and Somerville Program for Alcoholism and Drug Rehabilitation Cambridge MA

January 25, 2012 Senate Lounge, State House

- Review of draft report and findings
- Recommendations and future work

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**FINDINGS**

- **Our emergency departments currently face an over utilization of high cost, high levels of non urgent behavioral health usage that could be appropriately treated in alternative settings.**

According to estimates from 2008 Medical Expenditures Panel Survey (MEPS)<sup>2</sup>, a set of large-scale surveys of families and individuals, their medical providers, and their employers across the United States, the average amount paid for a nonemergency visit to an emergency department (ED) was \$792, while the average amount paid for a health center visit was \$108. Similarly, the average charge for a non emergency visit to an emergency department was 10 times higher than the charge for a visit to a health center—\$2,101 compared to \$203. Typically, hospital charges reflect the amount the hospital billed for the entire hospital stay and do not include professional (physician) fees. The charge is generally more than the amount paid to the hospital by payers for the hospitalization and is also generally far more than what it costs hospitals to provide care.

Several commission members discussed the high usage of emergency department for non urgent behavioral health and/ or substance use disorder needs (*Commission hearing, November 9, 2011*). One particular hospital provider reported an on average cost of \$650 per patient, including basic hospital and physician charges. This estimate excludes other costs including medications, personnel charges and overhead charges.

*“We are providing an extremely expensive taxi through the use of municipal ambulances and RIH is the most expensive hotel in the City for this population with an average stay of \$650 for a turkey sandwich and place to sleep.”- one physician member, November 9, 2011*

In addition to these estimates, several physicians described their personal experience in treating patients with behavioral health/ substance use disorders in emergency department settings who were not experiencing other urgent medical needs. The physicians concluded that these individuals could be treated more effectively in alternative settings and perhaps receive more comprehensive supports and referrals.

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<sup>2</sup> 2008 US Medical Expenditures Panel Survey (MEPS).

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Healthcare providers described the difficulties and complexities with calculating reimbursements for emergency department visits annually including:

1. Complicated and evolving;
2. Approximately 54% of costs are unpaid;
3. Low end estimate of approximately \$900,000 unpaid;
4. Does not include Pre-Hospital charges such as overhead, pre admission;
5. Large amounts absorbed by local fire and police departments (including an estimated \$800,000-\$1.3M annually of unpaid services are absorbed by the City of Providence.

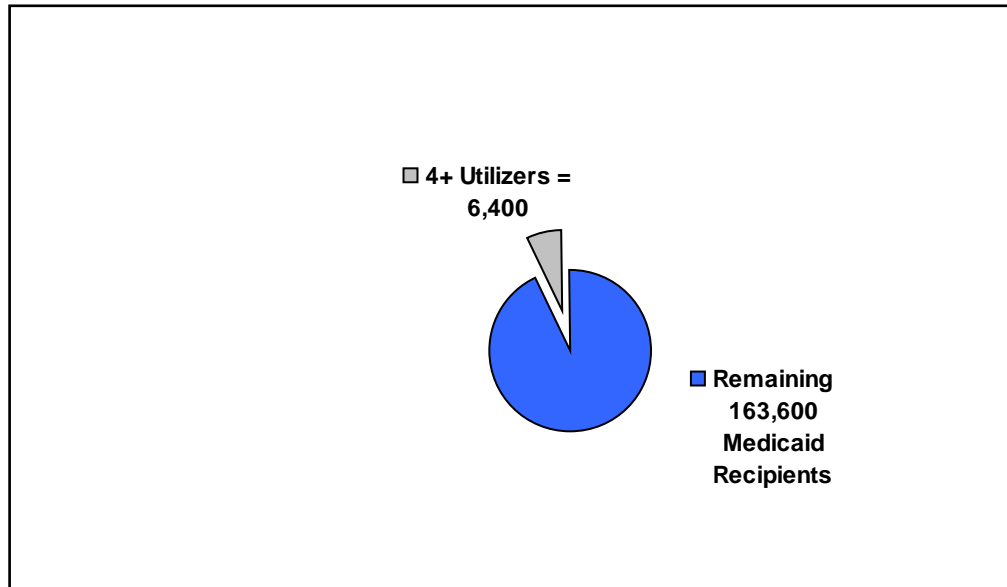
Deborah Florio, Administrator Center for Child and Family Health at Rhode Island Department of Human Services (DHS), revealed significant Medicaid data through a DHS Initiative, *Communities of Care: Rhode Island's Emergency Diversion Project (Commission Hearing, November 30, 2011)*. The Communities of Care (CoC) Project examined high frequency emergency department usage among Medicaid clients and implemented strategies designed to reduce high frequency ED usage. Ms. Florio described the Medicaid emergency department cost data (million) by year which consists of:

	Medicaid ED Expenses
2005	\$36.2m
2008	\$52.1m
2012 Projected	\$84.7m

Additionally through analysis of Rhode Island Medicaid data in the CoC Project, a total of four percent of high utilization Medicaid ED users (4+ visits annually) account total cost: \$20.6 M - 40% of the cost per year for Rhode Island Medicaid ED visits (DHS, 2008). The cost of this system use is extremely high, due to the disproportionate use of services, thus illustrating how significant this small subset contributes substantially to rising state Medicaid costs.

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### High Utilization by a Relatively Small Number of People



- **Our municipalities face significant costs and personnel stressors for transporting individuals with non urgent behavioral health/and/or substance use disorders to emergency room departments**

Testimony from the Providence Public Safety Commissioner on November 30, 2011 revealed that the Providence Emergency Medical Service (EMS) currently ranks first as the most affected RI municipality for rescue runs with 244 runs per 1000 residents. Each Providence EMS run costs \$580.02 and in fiscal year 2010 the cost to the City was \$15,962,220.00 with reimbursements in the amount of \$4 million. Additionally, the Commissioner noted that many “frequent users” cycle in and out of the emergency room departments (via EMS transport), sometimes multiple times on a daily basis, while under the influence of alcohol or substances. Individuals are released from the ED once their blood alcohol concentration returns to lower levels, based upon observational factors.

Commissioner Pare urged the Commission to consider the importance of diversion and treatment and ways to deliver more appropriate care to individuals, including those who are experiencing true medical emergencies, without further taxing the system. According to the Commissioner, EMS personnel estimate that 10% of ambulance transports were for actual medical emergencies,

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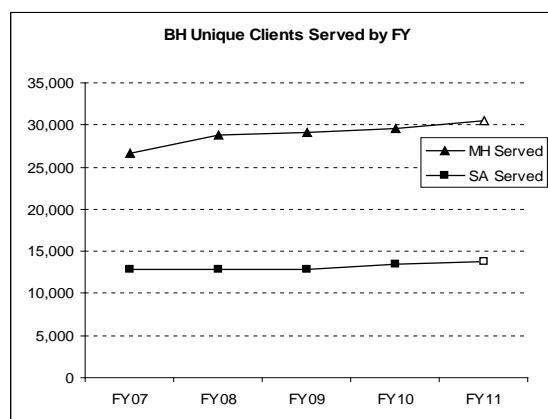
which raises a great deal of concern that those individuals with true medical emergencies may receive delays in emergency transports due to the lack of available resources.

The Commissioner also discussed the secondary impacts on Emergency Medical Technician (EMT) personnel responding to an average of six calls while on duty that can often lead to high stress, burnout and turnover rates. Additionally, there was some consensus among commission members regarding the potential for municipal Emergency Management Services to examine alternatives to transporting individuals with non urgent substance use/behavioral health issues. While there were no definitive recommendations, the importance of continuing to address and assist cities and towns in delivering comprehensive and cost effective services for all Rhode Island residents is a critical issue.

- **Our patients and providers face significant treatment access issues: patient obstacles; third party limitations; budget and resource limitations.**

While the goal of our healthcare delivery system is widely described in the literature to provide care that is managed across settings, continuous over time, and patient-centered- our system still has substantial barriers for both providers and patients.<sup>3</sup> Rhode Island currently ranks the highest nationally for mental illness with 24.2% of the population reporting any mental health illness and 7.2% reporting serious mental illness. The prevalence of both mental health and substance abuse disorders and the demand for service is evident in the number of clients that have been served in Rhode Island since 2007.

BHDDH Data presented, December 14, 2011



<sup>3</sup> Sara J. Singer et al., *Defining and Measuring Integrated Patient Care: Promoting the Next Frontier in Health Care Delivery*, 68 MED. CARE RES. REV. 112, 113 (2010) (defining integrated patient care as —patient care that is coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to the patients’ needs and preferences; and based on shared responsibility between patient and caregivers for optimizing health. );

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Individual experts who presented before the Commission described the myriad of factors in play when dealing with non emergent behavioral health/substance use issues in the emergency department including quality care, patient safety, costs and significant barriers as they related to third party reimbursements, including:

- lower rates of reimbursement for mental health services;
- Restricted medication formularies;
- High out of pocket co-payment costs;
- Lengthy pre-authorizations

These factors oftentimes contribute to the lengthy wait times for hospital inpatient beds, difficulty with care coordination among providers and lack of adequate and appropriate resources for patients.

- **Our state system currently provides funding for alterative stabilization units for those diagnosed with psychiatric disorders but limits eligibility criteria through regulations, significantly reducing access for those with active substance use disorders in need of services.**

Providers presented positive findings and results on creative models that are currently operating in the state with success in stabilizing patients experiencing psychiatric episodes through medical, educational and therapeutic services. While these programs have been designed and implemented with a patient focused model for a variety of reasons including patient and personnel safety. Unfortunately, the current state regulations limit eligibility criteria, excluding those who are intoxicated or under the influence of substances from entering and receiving the appropriate services.

Developing a system which also creates linkages and access for individuals actively seeking immediate services for active substance use disorders and/or behavioral health issues is critical in meeting the demand and potentially reducing frequent non urgent emergency room visits. It is critical to examine both the positives of the system as well as gaps in order to appropriately address the demand and increasing need for services.



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- **Current Department of Health state ambulance advisory council protocols for individuals with behavioral health/ substance use disorders prevent Emergency Medical Technicians from transporting individuals to settings other than an emergency department by mandating screening by licensed physicians.**

Testimony from various presenters revealed that one of the significant obstacles in examining opportunities for alternative facilities and treatment outside of an emergency room department was related to the *Rhode Island General Laws 23-1.10-1 Treatment and services of intoxicated persons and persons incapacitated by alcohol*. The current definition of “emergency treatment” requires that treatment be provided by a facility affiliated with or part of the medical service of a general hospital; thus significantly limiting the possibility of delivering services for those who meet the medical clearance, from admission to alternative settings. In addition, the statute also limits medical clearance of clients to licensed physicians, significantly reducing the potential for qualified providers (such as licensed physician’s assistants, nurse practitioners and others) to medically assess individuals, as currently successfully implemented in several states throughout the country.

- **Coordination among healthcare providers and the delivery system is fragmented- for individuals with behavioral health/ substance use disorders lacking a continuum of comprehensive, integrated emergency services including detoxification, treatment, social service and housing supports.**

Providers expressed concern that patients face significant challenges due to a lack of coordination and barriers that prevent individuals from being able to obtain the necessary clinical and non clinical services. Among factors

*“We cannot simply legislate all these changes. The legislative changes are necessary but not sufficient; we need to further develop a system to support the needs of this population”-one commission member noted November 30, 2011*

that contribute to patients’ difficulty in navigating the system include:

- Symptoms of illness;
- Lack of resources to access care;
- Lack of transportation or telephone;
- Need for after hours medical care;
- Living in supervised housing/shelter.

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The importance of coordination and assistance from the comprehensive provider network that manages both clinical and non clinical needs is essential in a client's ability to access the necessary services as well as deliver a continuum of care to individuals. The state has many dedicated professional, non-profit behavioral health and social service organizations supported by state funds that deliver quality patient centered services. There are however, apparent gaps in the specific continuum of services which leads to extreme challenges for clients seeking comprehensive services. With Rhode Island's small geographic area and concentration of providers (often located within the Providence- metro area), the ability to track and coordinate services for individuals should be achievable.

- **Nationally, there are demonstrated models that provide quality care for individuals with behavioral health and/or substance use disorders outside of hospital emergency departments that document improved health outcomes.**

In San Francisco, California the City established a model medically supervised sobering center designed to divert intoxicated persons from the ED to a 24-hour central facility providing medical screening, integrated case management services and linkages to a comprehensive continuum of care. Outcome data from the 1200 unduplicated clients who received services in the setting showed a 40% improvement in health outcomes as well as 26% referred for case management or other resources. <sup>4</sup>

Central City Concern located in Portland Oregon is another alternative model that has been in successfully operational since the early 1970s with a roving van throughout the inner city to transport inebriated individuals to the Sobering Program. Called CHIERS, the van is staffed by EMTs trained to work with alcoholics, substance abusers and the mentally ill, thus providing significant assistance to the police. Rather than take intoxicated people to jail, CHIERS staff and the police bring them to the Sobering Program where they can get sober in a safer, appropriate environment. After being assessed by Emergency Medical Technicians (EMTs) to be sure no critical medical needs are present, clients spend 3-5 hours getting sober and learning about potential next steps in their treatment and recovery. This past year the sobering center saw 8,400 clients and the CHIERS van brought 2,200 unduplicated admissions to the program <sup>5</sup>

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<sup>4</sup> City and County of San Francisco McMillan Stabilization Pilot Project Six Month Interim Report (Aug 2003- Jan 2004).

<sup>5</sup> Central City Concern, Portland Oregon [www.centralcityconcern.org/changing-lives/sobering\\_station.html](http://www.centralcityconcern.org/changing-lives/sobering_station.html)

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Additionally, the Director of the CASPAR Sobering Center, Cambridge MA presented before the Commission on January 11, 2012 to reveal findings and information of their prevention and emergency services model for dual diagnosed individuals that has been effectively operating since 1979 with 110 bed capacity. The facility provided services to 1,108 individuals in 2011 with the following data:

*"Beyond the charge of this commission, I urge members to continue their commitment to this issue. It is critical to leverage partnerships with both formal and grassroots organizations in order to successfully implement these strategies." The Director of CASPAR January 11, 2012*

- 21% clients went to permanent housing
- 28% clients continued in other CASPAR programs
- 65% moved forward in the continuum of care

The model operates under the philosophy that each individual is treated using a strengths based approach utilizing prevention, risk assessment, and treatment services as early as possible. CASPAR integrates an outreach component to the work, by working in partnership with the Cambridge Police to train outreach workers that have the ability to directly transport individuals identified through 911 dispatch calls and transport to their emergency services center.

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**RECOMMENDATIONS**

- 1. Amend the existing RI alcohol statute to create a pilot program to make it more flexible by allowing, but not requiring, such persons to be evaluated in alternative community-based settings by defined licensed healthcare providers, if deemed appropriate.**

Any recommendations to improve systems and develop alternatives require include legislative changes to *Rhode Island General Laws 23-1.10-1 entitled, Treatment and services of intoxicated persons and persons incapacitated by alcohol*. As discussed in commission hearings the current law is extremely prescriptive by defining the location (emergency treatment- emergency department) as well as requiring examination by a physician. This currently precludes individuals who are intoxicated or under the influence to be brought to another facility, even on a pilot basis.

The Commission recommends establishing a three year pilot program, designed for a specific geographic area. The amendment could include such language as: “A person who comes voluntarily or is brought to an approved public facility. The new section of law may establish a pilot program for an approved alternative facility under the authority of BHDDH, with clear parameters and outcomes as well as reporting requirements, BHDDH would issue a Request for Proposals and establish rules and regulations for the facility to operate, on a pilot basis, in order to demonstrate the effectiveness for potential permanent programs.

- 2. Create state- wide care partnerships to enhance patient- centered systems of care to include on-demand services, 24 hour triage center programs, mobile outreach transportation teams, and telephone triage systems for substance use disorders/behavioral health issues.**

The issue of developing a patient centered coordinated system of care has remained one of the most discussed topics surrounding healthcare for a significant number of years. The advent of federal health care reform has made establishing coordinated services that maintains quality patient centered care a high priority with healthcare providers, hospital systems and even insurance providers.

“...the assurance that each patient gets the right care in the right setting including routine, non-emergency care seven days a week in a primary care setting, with emergency room care only when needed.” Peter Andruszkiewicz, the president and CEO of Blue Cross and Blue Shield of Rhode Island, *Providence Journal OP ED* December 15, 2011.

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One potential model for consideration is the Cambridge and Somerville Program for Alcoholism and Drug Rehabilitation (CASPAR, Inc) which provides a comprehensive continuum of care through coordination of patient centered treatment for non emergent substance use and/ or behavioral health disorders, utilizing a full range of services from mobile outreach alternative transport services to 24 hour triage and relapse/ recovery oriented supportive services. The CASPAR First Step Community Outreach Team works from 8 a.m. until midnight in the suburbs of Boston to provide support and connections to services for individuals with substance use and/ or behavioral health disorders.<sup>6</sup>

The CASPAR community outreach team (alternative to EMS transport) interfaces with on average 50 clients per day and provides in depth training to connect individuals to appropriate services. The outreach budget is estimated at \$500,000 per year for comprehensive outreach and transportation services; and the complimentary emergency services and relapse prevention program has a modest operating budget of \$1,100,000 per year (1,100 unduplicated clients @ a cost of \$49.00 per day per client). CASPAR's operational budget is comprised of a majority of state funding including \$900,000 from the Massachusetts Bureau of Substance Abuse Services (BSAS), federal funds and a variety of private donations and in kind contributions from non- profit agencies. Cambridge and the surrounding metro area is significantly larger in geographic area and population size when compared in scale to the capital city of Providence.

Following testimony from the CASPAR Inc. director, commission members discussed the potential to create a pilot program with integrated outreach, alternative transportation and emergency shelter services in Rhode Island. In order to achieve a similar model that would serve individuals who are actively under the influence of alcohol or substances as an alternative to the ED, the facility must have the ability to deliver the appropriate levels of care, staffing (i.e. licensed physicians, psychiatrists, nurses, social workers), support services, liability insurance and licensing/ medical protocols.

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<sup>6</sup> Labiosa, Wilfred. Presentation to the Special Senate Commission to Study Emergency Department Diversion. January 11, 2012 PowerPoint Presentation.

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**3. Support opportunities through Health Homes Medicaid enhanced funding, to include person centered on-demand, substance use and/ or behavioral health care and transitions to community supports.**

Rhode Island's Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH) was one of two state applicants to achieve national distinction by receiving a state plan enhancement amendment of \$12,171,505 (representing a 90% federal medical assistance match over two years) to integrate primary care and behavioral health services and build a person-centered system of care to achieve outcomes for beneficiaries. The population eligible for the grant in Rhode Island consists of the following: individuals with (2) chronic serious medical issues including mental illness- Serious Persistent Mental Illness population (SPMI), and, one additional serious medical diagnosis. Among the outcomes that the department hopes to achieve are decreases in preventable emergency department usage visits and prevention of readmissions and better health outcomes.

While the commission focused on individuals with behavioral health and/ or substance use disorders, the director of BHDDH stated in a commission hearing, that in order for an individual to be deemed eligible for the grant, they must meet the strict eligibility criteria in order to qualify for services. Additionally, although this funding **cannot pay** for an alternative facility, there **may** be future opportunities available, if Medicaid and eligibility criteria are met, to deliver on demand, comprehensive wrap around services and supports to deter non emergent high frequency emergency department usage (*Commission Hearing, January 25, 2012*).

**4. Support a pilot program for the coordination and implementation of an evidence based suicide/ mental health assessment tool and training for Rhode Island healthcare providers and first responders for determination of placement in emergency department or alternative settings.**

Testimony by a Pawtucket police officer revealed significant concerns that law enforcement have with individuals that are under the influence of substances or intoxicated and refusing services or treatment when picked up for disorderly conduct or related charges. He explained the dilemma that law enforcement face when they refuse to go to treatment or an emergency room department (*Commission Hearing, November 30, 2011*). The officer highlighted the important and timely

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decisions that law enforcement must make when confronted with individuals with behavioral health/ substance use disorders. The limited training that law enforcement often receives outside of the police academy was discussed and the importance of providing our first responders with the appropriate tools to assess an individual was identified as a necessary tool.

A Centers for Disease Control and Prevention (CDC) report indicated that, while Rhode Island had the highest rate of suicide attempts, it had one of the lowest suicide death rates.<sup>7</sup> As this issue presents, there are validated screening assessment tools that not only assess suicidal behavior, but are also significantly valuable in predicting suicidal attempts. Examining the use of a validated screening assessment tool state wide which would allow first responders and healthcare providers to utilize a standardized tool that would assist in the field in making an informed, objective decision in assessing one's suicidal behavior would be an effective strategy.

A commission member provided an overview of one instrument that his behavioral health center is currently in the process of implementing; the Columbia- Suicide Severity Rating Scale (C-SSRS). The instrument has been used as a standardized assessment tool that has the ability to predict what triggers behavioral incidents. This scale has been utilized successfully world-wide in intervention studies and clinical trials across a broad range of disorders and diseases, and by institutions from the US Military to the World Health Organization to local fire departments (*Commission Hearing, December 14, 2011*). By exploring the potential for implementing a validated assessment tool on a pilot basis, with first responders and community health organizations with a selective population, to determine level of interest in training and implementation, this recommendation may serve to assist those in the field with an additional tool for everyday use.

**5. Support the development of a pilot program proposal and protocols for  
Emergency Medical Services (EMS) transports to alternative facilities.**

The Rhode Island Department of Health Director oversees all regulations pertaining to EMS ambulances and practitioners. During the hearing, the Chief of the Division of EMS presented information that-- although the *RI Prehospital Care Protocols and Standing Orders, protocol 1.1:*

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<sup>7</sup> US Dept of Health and Human Services, Mental Health Surveillance among adults in US, *CDC Morbidity and Mortality Weekly Report*. 2011; S/vol 60

**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**

*Standard Management of All Patients* allows in certain instances for individuals to be sent to alternative setting depending on their diagnosis. However, those with behavioral health issues are sent to emergency departments due to the protocol that dictates that location (*Commission Hearing, December 14, 2011*). In order to allow increased flexibility with transports for this specific population, one potential policy option presented was for an entity to develop a proposal to the Department of Health to create a new stand-alone protocol for patients with behavioral health issues or include provisions in an already established EMS protocol. If the protocol were to be considered, it must meet specific medical clearance and criteria that already exists for individuals to be sent to an alternative facility. In addition, the protocol must have strong use of medical control, quality improvement and assurances in place.

**6. Support opportunities to enhance or reinvest savings for best practice housing models that include supportive services and employment/ training linkages.**

There are several model housing programs that exist to create a stable place for individuals. One such model is the Housing First Program- which involves rapid access to permanent housing with voluntary access to a variety of services. In 2005, the state of Rhode Island and the United Way

*A lead state director overseeing the behavioral health and disabilities in Rhode Island, emphasized the critical component of housing for individuals with behavioral health/ substance use disorders, "...without housing and appropriate supports we cannot expect an individual to succeed." December 14, 2011*

of Rhode Island created a program modeled after Housing First to address our chronic homelessness by housing 50 homeless single adults in subsidized apartments and by providing those clients with the services they needed to stay housed. Estimates show a per person savings of \$8,839 as compared to current year costs of institutional services, cost of supportive services and cost of housing subsidies which on average total \$22,778 to the prior year cost for institutional services of \$31,617.<sup>8</sup>

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<sup>8</sup> Eric Hirsch, *Rhode Island Housing First Program Evaluation 2005-2007*, November 2008.



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**7. Support the department of behavioral healthcare developmental disabilities and hospitals in exploring opportunities for funding the alternative pilot program.**

There was much discussion during the final hearing on January 25, 2012 regarding potential funding mechanisms for the pilot program to be developed and administered through BHDDH. Several members noted the importance of having a broad variety of funds available to support the operation of the program and to conduct a comprehensive evaluation of the effectiveness of the program. Several possible funding sources were identified for the pilot program including; hospitals, third party insurers, Medicaid and municipalities. As the state faces another difficult fiscal year, it will be essential to explore potential financial commitment from these entities which will be critical in actualizing the implementation of the pilot in the near future.

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**From:** Chris Stephens [mailto:cstephens@nricommunityservices.org]  
**Sent:** Tuesday, January 24, 2012 10:49 AM  
**To:** Caitlin Thomas  
**Subject:** RE: Draft Version Emergency Department Diversion Report

Excellent document. ...since I am out of town for the final hearing on the draft report, can I submit the following ?..".NRICS , the community mental health center serving Northern RI, strongly endorses the recommendations of the Commission and wishes to submit the following "edits" for consideration 1) Delete the "/behavioral health" nomenclature throughout the document. Rationale: In almost all cases where it is used the "substance use" reference is sufficient; it is important to recognize that the MH and SA systems have very different funding, systems of care, providers,etc. It is also important to public support and funding, to understand the primary problem to be related to the diversion of chronic SA clients.2) In the section on CMHCs and Medical Homes insert the language" clients with co-occurring mental illness and an addictive disorder or a major substance abuse problem" As written the paragraph will lead some readers to think there is additional funding and an additional mandate to serve chronic inebriates via the Medicaid Health Home; neither is the case. On behalf our many psych clients successfully avoiding ER and input use, and on behalf our "ASU" for co-occurring clients and and SSTAR-RI new efforts regarding acute residential SA treatment , thank you for placing such a targeted focus on the need for a "sobering center"; your Commission captured the biggest and most discussed gap in the RI substance abuse system"...Christian L. Stephens, Pres/CEO"

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**NRI Community Services, Inc**

*A Non-Profit Provider of Mental Health & Substance Abuse Treatment*

www.NRICommunityServices.org

MAILING ADDRESS:


PO Box 1700

Woonsocket, RI 02895-0856

PHONE: 401 235-7000

EMERGENCY: 401 235-7120

To: Special Senate Committee  
ER/Inpatient Diversion

From: Christian L. Stephens, President/CEO   
NRI Community Services, Inc.

Re: Suggestions

Date: January 17, 2012

The recommendations of NRI Community Services (“NRICS”) are based on 30 years of service development dedicated to reducing inpatient care and developing community based alternatives for both acutely ill and chronically ill behavioral health clients. NRICS has historically performed better than most providers in reducing admissions and length of stay at Eleanor Slater and other state funded inpatient beds because of our multipronged approach to diversion. Some suggestions that emerge from our experience include:

1. Identify and target subgroups within the ER “overusers” because they have very different needs. The testimony and notes from the Commission hearings could mislead tax payers and members of the General Assembly. The causes and solutions are very different for: parents of children and adolescents with insurance but troubling behavioral issues; homeless veterans alienated from the VA system; opiate addicted and pain medication seeking adults; seniors without homecare; mentally ill in need of immediate medication adjustments; acute or chronically intoxicated students and unemployed, etc.

Recommendations

- A. Require the Division of Behavioral Healthcare (DBH) to require all of its vendors to give priority access to new clients from hospital diversion programs, from emergency rooms, and recent hospital discharges.
  - B. Require the Department of Human Services and FQHCs to a higher standard of interagency care coordination and collaboration when treating acute clients shared with community based agencies (e.g., DD providers, CMHCs, CAPs, state funded providers).
  - C. Require “managed Medicaid” health plans to create an enhanced rate for intensive home based behavioral health services (currently do for office based day programs only).
2. Require a higher standard of ER diversion efforts for all agencies participating in Medicaid, indigent funding, and/or state contracts.

NRICS is a not for profit multiservice organization providing crisis intervention, community housing, casemanagement/service coordination, child & family intensive services, outpatient and residential treatment for adults with co-occurring mental health and substance abuse challenges, and other special services. These programs are nationally accredited by CARF and licensed and certified by the State of Rhode Island. We are a member of the Fund for Community Progress, The National and Rhode Island Councils of Community Mental Health Organizations, and United Neighborhood Centers of America.

## SPECIAL SENATE COMMISSION TO STUDY EMERGENCY DEPARTMENT DIVERSION

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*Special Senate Committee  
January 17, 2012  
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### Recommendations

- A. Eliminate funding to agencies that operate 9:00 – 5:00 by requiring that they develop, or contract for, a 24/7 emergency on call capacity as a cost of doing Medicaid business.
  - B. Eliminate off-hours practice of state funded agencies of referring callers in crisis due to psychosocial problems, to “call 911 or report to the nearest ER”. Require agencies to refer clients to help lines, on-call staff, community self-help resources, and/or partnering agencies during off-hours.
3. Challenge the professional bias that the best services are always the most integrated, normalized and non-congregate. Encourage development of a limited number of specialized 24/7 beds for special populations that have or will put demands on ERs and inpatient behavioral health beds in the future.

### Recommendations

- A. Restore and increase Assisted Living Residence funding for the poorest of Rhode Islanders, paid via the “SSI enhancement”.
  - B. Request the Division of Behavioral Healthcare to increase residential care reimbursement to actual cost; allow some shrinkage of beds if the state has to stay cost neutral (better to have fewer but financially stable beds available for the uninsured).
  - C. Modify licensing processes by DCYF and DBH to expedite new, lower cost supported housing options.
  - D. Eliminate “any willing provider” stance at DBH regarding Acute Stabilization Units; DHS prevent “over bedding” of hospital diversion beds and financial destabilization of the current units.
4. Monitor when the largest CMHCs contract with hospitals to provide ER mental health triage and admission for community hospital psychiatric units. There may be excess inpatient capacity and built in incentives for hospitals and partners to direct clients to ERs and psychiatric units to support hospital census.

### Recommendations

- A. Restore Certificate of Need for any inpatient bed changes or increases.
- B. Change Utilization Review law to make it easier for community providers and ERs to discharge insured ER patients to a non-hospital alternative.
- C. Improve public review of hospitals’ contracting practices; monitor “steering”, limiting consumer choice and rewarding inpatient referrals.

## SPECIAL SENATE COMMISSION TO STUDY EMERGENCY DEPARTMENT DIVERSION

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5. Raise the profile regarding the psychiatric shortage in the community agencies of both child and adult psychiatry. Many “boarding” situations in ER and inpatient admissions are the result of limited hours of MD and PCNS time in CMHCs and FQHCs, due to poor reimbursement.

### Recommendations

- A. Insist on Department of Health updating health professional shortage designations with Health Services Corp. and eliminate the bias that only FQHCs are treated as shortage areas.
  - B. Advocate that health plans raise rates for psychiatry reimbursement in order to retain more and qualified psychiatrists. Eliminate state and health plan biases against the hiring of Nurse Practitioners/prescribing nurses.
  - C. Encourage open access scheduling and better delineation of emergency psychiatry time for medication adjustments to reduce inpatient admissions of behavioral health clients.
6. Create some oversight of the Department of Administration Office of Purchasing. State Departments often manage the RFP process and influence an objective scoring of proposals. Often RI state departments appear to hand pick their favorite or preferred provider despite the bid process.

### Recommendations

- A. Require funding be indexed based on socio economic conditions in the service area. Many contract amounts, that are rebid, are historical and not based on demographics.
- B. Require any indigent funding RFPs for residential and for outpatient be issued, compared, and awarded at the same time. The current practice of bidding these at different times increases disorganization of the delivery system.
- C. Require that any proposal providing the most service units to clients for the amount of the state RFP receive the full points for “cost score” (e.g., if 10 out of 100 points go to the best cost, then the lowest cost proposal should get all 10 points and others 0 points).
- D. Create more stability in the publicly funded, nonprofit provided, health and human service system by exempting some services from mandated, periodic rebidding. Organizations can retool when experiencing state cuts, but whole shifts in vendors results in less efficiency and higher costs.

**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**

To: Senator Paul Jabour & Senator Joshua Miller  
From: Craig Stenning, Director, BHDDH; Dale Klatzker, President/CEO, The Providence Center; Elizabeth Earls, CEO, RICCMHO; and Neil Corkery, President, DATA RI  
Re: Senate Commission to Study Emergency Department Room Diversion Policy Recommendation  
Date: January 20, 2012

As the Special Senate Commission to Study Emergency Department Room Diversion has demonstrated through its meetings and the testimony of experts, the overreliance on emergency rooms as a source of treatment for individuals with behavioral health issues, is both expensive and does not provide these individuals with the right care, at the right time, and in the right setting. As a means of addressing this issue going forward, we respectfully propose the implementation of a pilot project (presumably in Providence) which would allow the State to bring together all relevant players in this situation--local government entities, hospitals, community based providers, and other social service agencies --- in order to create a comprehensive plan to divert individuals with behavioral health issues from the emergency room to more effective levels of care. The pilot's design would be based on models currently employed in Massachusetts and California both of which have shown an ability to improve health outcomes for these individuals while also reducing overall system costs.

**The Problem:**

In testimony before the committee, Providence Public Safety Commissioner, Steven Pare described how current state law requires that all ambulances transport individuals they pick up (regardless of their behavioral health condition) to an emergency department. This has resulted in Providence's Emergency Medical Service being often dispatched to non-emergent incidents with no viable alternative other than to transport an individual to the emergency room. As a result of this situation, Providence has one of the highest rates of emergency runs in the country at 244 runs per 1,000 residents. With a per run cost of \$580, the 27,459 runs in Providence, cost the city almost \$16 million in 2010, of which only \$4 million was recovered from insurance. In addition, Pare estimated that only 10 percent of the runs were for true emergencies, meaning that the vast majority of the runs were for non-emergency care. In regards to behavioral health issues specifically, Pare estimated that over a two month period in 2011, the city spent almost \$1 million in transporting intoxicated/behavioral individuals to the emergency room.

**The Emergency Room Diversion Pilot Proposal:**

The Emergency Room Diversion Pilot would bring together state and city government entities, the hospitals, community-based primary and behavioral health care providers, and other social service agencies to begin to create a comprehensive system which would work to ensure that individuals with behavioral health issues were able to access the right level of treatment, at the right place, and at the right time, without needlessly sending everybody through the emergency room. The proposal would call for a one year pilot project (to begin July 1, 2012) with an evaluation component that would allow the state to determine which aspects of the program hold the greatest potential for further application.

In order to effectively implement the pilot project there are a number of concrete action items that would need to be undertaken:

**Legislative Action:** For the purposes of the pilot, the state could waive the requirement under current Rhode Island state law (23-1.10.10) that an intoxicated individual who is picked up by an ambulance de facto be taken to an emergency room. Instead, emergency medical technicians

## **SPECIAL SENATE COMMISSION TO STUDY EMERGENCY DEPARTMENT DIVERSION**

should be given the ability to make an assessment of the individual, and if medically appropriate, transport the person to an alternative community-based setting.

**Create Homeless/Frequent User Outreach Response Team:** In order to reduce demand on the city's emergency medical services, a community-based homeless outreach response team could be created. The team would include a certified emergency medical technician, with access to a medical vehicle (not necessarily an ambulance), and could operate 24 hours a day seven days a week. This team could coordinate with EMS and Police, and could respond to calls involving inebriated homeless individuals as well as other frequent users of emergency medical services who have a known behavioral health issue. The certified EMT would perform an initial medical screen to determine what level of care the individual needed, and then transport (or facilitate) these individuals to the appropriate level of care, which could include a 24/7 central facility .

Community-based settings could include community health centers community mental health organizations, acute/crisis stabilization units, and approved day and night shelters which have access to medical support services. Obviously the person could also be transported to an emergency room if it was determined that level of care was necessary.

**Develop Continuum of Community-Based Care:** In order to ensure consistent access to an alternative to the emergency room, we would propose that the State or pilot city create a medically supervised sobering center that could operate 24/7. This facility, which would be managed by peer workers with 24-hour a day EMT medical support would provide medical screening, comprehensive case management, and linkages to a full continuum of care.

Currently if the pilot were to be located in Providence, the City of Providence has access to many of the services needed to effectively meet the various medical and behavioral health needs of the target population. Providers that could be asked to take part in this program would include: the hospitals (RIH, Miriam, RWMC); Providence Community Health Center (with particular emphasis on the new urgent care facility which is scheduled to open at their new Prairie Avenue facility), The Providence Center's Crisis Stabilization Unit, detoxification services through the state funded RESPECT program, and shelters including the recently established Emanuel House Day Shelter located on Public Street in Providence. Under this concept direct transportation could be made to any of these providers, either by the homeless outreach response team or by Providence EMS or Police.

In addition to serving as facilities where individuals with behavioral health issues could be diverted to, the inclusion of the community-based providers will allow for improved access and coordination of services including: treatment services; recovery services; housing support; and vocational services. Through this pilot we will be able to reduce up-front costs for treating this population, while also improving their long-term health outcomes by linking them in to ongoing treatment. For example, a similar effort in California involving approximately 1,200 individuals showed that within 6 months of implementing the project 40% of individuals showed improved health outcomes, and 26% were assessed for case management services.

### **Funding:**

In the state's FY 2012 budget funding for indigent detox services was reduced by approximately \$1 million. We would propose restoring a portion of this funding to help fund the cost of the space, staffing (which would be needed 24/7 at the central facility, and to cover the outreach team seven days a week 12 hours a day) and peer staff which would staff the facility. Similar efforts in other

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cities have relied on funding from hospital providers, as well as state and local governments. If the hospitals were able to contribute some portion of the cost of the program that would reduce the state's cost for the effort. While the amount of funding is significant, the savings in ER and EMS costs, improper utilization of the emergency room, and improved health outcomes should more than offset any increased state/city expenditures.

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**STATE OF RHODE ISLAND**

**IN GENERAL ASSEMBLY**

**JANUARY SESSION, A.D. 2011**

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**SENATE RESOLUTION**

**CREATING A SPECIAL SENATE COMMISSION TO STUDY RHODE ISLAND  
EMERGENCY DEPARTMENT ROOM DIVERSION**

**Introduced By:** Senators Perry, Crowley, Jabour, Metts, and Miller

**Date Introduced:** April 14, 2011

**Referred To:** Senate Health & Human Services

SECTION 1. WHEREAS, untreated substance use disorders, problems of homelessness, poverty and chronic illness contribute to poor health outcomes and frequent use of hospital emergency departments; and

WHEREAS, the underlying need for clinically appropriate diversion includes: increased complexity and acuity of patients presenting to emergency departments; increase in patient volume; lack of beds for patients admitted to hospitals; and shortage of physical space within the emergency department; and

WHEREAS, in 2008 the Rhode Island Medicaid program reports spending a total of \$52 million on emergency department expenses alone; and

WHEREAS, Visits to the Emergency Department are generally the most costly form of care, but not always the most effective alternative for care; and

WHEREAS, according to the 2006 National Survey on Drug Use and Health the total

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number of individuals dependent on or abusing alcohol and drugs was 107,000 or 11.34% percent of the 12 or older population in Rhode Island; and

WHEREAS, Diversion is the practice of redirecting an ambulance away from a hospital's emergency department when clinically appropriate, and has become a well-documented national practice; and

WHEREAS, Diversion may be one strategy to cope with the temporary mismatches of demand for emergency care and supply of emergency care treatment capacity, and

WHEREAS, Public emergency departments could refer large numbers of patients to appointments at alternative care facilities if the availability and coordination of primary care services were enhanced to provide comprehensive clinical supports; and

WHEREAS, that the senate hereby establishes a special senate commission to convene to discuss and develop short-term and long-term strategies to improve hospital service delivery and utilization of emergency departments in order to meet the health needs of Rhode Islanders; now, therefore, be it

RESOLVED, that the special senate commission to study Rhode Island emergency department diversion is hereby created and shall consist of nineteen (19) members to be appointed by the senate president, as follows:

Three (3) of whom shall be members of the senate, not more than two (2) from the same political party; one of whom shall be the director of behavioral health disabilities and hospitals, or his or her designee; one of whom shall be the director of human services, or his or her designee; one of whom shall be the director of department of health, or his or her designee; one of whom shall be a representative from an independent hospital; three (3) of whom shall be representatives from hospitals affiliated with a major health care system; one emergency room physician; one representative from the Rhode Island ambulance service advisory board; one representative of a local police department; one representative of a local fire department; one representative from a Medicaid health insurer; one representative of whom shall be a researcher/epidemiologist

**SPECIAL SENATE COMMISSION  
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specializing in substance use disorders; and three (3) of whom shall be representatives of community based providers that serve the substance abuse, mental health and/or uninsured populations. The commission shall have two (2) co-chairs from among its members, to be appointed by the president of the senate.

The commission shall be charged with studying and making recommendations regarding the issue of emergency room diversions for individuals with substance abuse disorders. In studying this issue the commission is encouraged to:

- (1) Examine trends, current policies, and data pertaining to Rhode Island hospitals emergency department utilization and emergency department diversion;
- (2) Identify regulatory restrictions which currently prevent Rhode Island emergency diversion initiatives;
- (3) Provide a forum for state agencies, community-based organizations, faith-based organizations, volunteer organizations, advocacy groups and businesses to discuss challenges and solutions pertaining to emergency department diversion;
- (4) Examine current models that are being used by other states or municipalities to mitigate the problem;
- (5) Identify and seek ways to remedy gaps in alternatives, specifically in the area of making provisions for the availability and use. In particular, identify permanent funding stream options for emergency department alternative facilities.

Forthwith upon passage of this resolution, the members of the commission shall meet at the call of the senate president. Vacancies in said commission shall be filled in like manner as the original appointment.

The membership of said commission shall receive no compensation for their services.

All departments and agencies of the state shall furnish such advice and information, documentary and otherwise, to said commission and its agents as is deemed necessary or desirable by the commission to facilitate the purposes of this resolution.

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The joint committee on legislative services is hereby authorized and directed to provide suitable quarters for said commission; and be it further

RESOLVED, that the commission shall report its findings and recommendations to the senate no later than January 31, 2012, and said commission shall expire on May 31, 2012.

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TO STUDY EMERGENCY DEPARTMENT DIVERSION**

**Special Senate Commission to Study Emergency Department  
Diversion**

Notice of Meeting

DATE: Wednesday November 9, 2011

TIME: 2:30 PM

PLACE: Senate Lounge, State House

- 1) Senators Paul V. Jabour & Joshua Miller  
Welcome and Introductions
- 2) Patients overwhelm the ER: Presentation and findings of the Problem – Hospital Panel
- 3) Mack Johnston, Neighborhood Health Plan- Non Emergent Behavioral Health ED Usage and Health Care Reimbursements
- 4) Invited: Deb Florio, Department of Human Services-Medicaid reimbursements: findings, high cost case review
- 5) Roundtable Discussion- 10 minutes
- 6) Additional Business
- 7) Adjournment

**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**

**Special Senate Commission to Study Emergency Department  
Room Diversion**

**First Meeting Summary  
November 9, 2011**

**Chairman Paul V. Jabour** welcomed the Commission membership and thanked them all for their participation. Senator Jabour outlined the history and purpose of the Commission. He shared his goal of meeting at least four times before the end of January with a report being issued to the General Assembly. He pointed out the wide range of interests represented on the Commission and expressed confidence in the Commission's ability to consider and produce important findings and recommendations. The Chair also thanked the Commission for their willingness to participate.

**Co-Chairman Joshua Miller** thanked Senator Jabour for his remarks and outlined the background and history of the Commission, including the past work of the Hospital Study Commission and recommendation number nine which specifically relates to alternatives to behavioral health interventions. He shared his goal of meeting of developing concrete recommendations that the Senate can act upon with policy and legislation.

**-Dr. Otis Warren, Medical Associate and Rhode Island Hospital** and the Miriam Hospital presented on emergency services for intoxicated patients at Rhode Island Hospital including protocols, quality and safety issues and cost estimates for basic hospital and admissions. Dr. Warren commented on the disproportionate services provided to those who are intoxicated without complex medical needs. He remarked that "we are providing an extremely expensive taxi through the use of municipal ambulances and RIH is the most expensive hotel in the City or this population with an average stay of \$650 for a turkey sandwich and place to sleep." (Presentation included in addendum)

**- Mr. Lou Giancola, CEO South County Hospital** presented on South County Hospital's perspective as it relates to behavioral health issues and identified the college population as a main "user" of high frequency ED usage for chronic intoxication. Several strategies have been employed over the years, including triaging off site for high volume, safety considerations and the amount of community resources dedicated to this high demand for chronic intoxication.

**-Lynn Leahey, Director Patient Care Services** presented on the influencing factors of non emergent behavioral health issues in the emergency department including quality care, patient safety and costs. Ms. Leahey presented an overview of the rates of mental illness both nationally and as a state. Rhode Island currently has the highest rate of mental illness at 24%.<sup>9</sup> Ms. Leahey addressed the clinical presentation factors including homelessness, combativeness and outlined the admission process for behavioral health issues including the triage process, blood alcohol level

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<sup>9</sup> NSDUH Report is published by the Center for Behavioral Health Statistics and Quality, and Substance Abuse and Mental Health Services Administration. (SAMHSA). October 6, 2011.

## **SPECIAL SENATE COMMISSION TO STUDY EMERGENCY DEPARTMENT DIVERSION**

(BAL) required within legal limits for discharge. At RWMC- all patients are given a satisfaction survey. One of the “chief complaints” is the wait times for assessment and admittance as well as lack of resources on the weekends. RWMC has utilized CNAs and MH workers to assist with the resource issue on “off hours”. Behavioral health (bh) is a strategic area for Charter Care and as a result they have started implementing a series of initiatives including staff development- through monthly trainings on bh issues that clients are facing.

**- Dr. Susan Szulewski, Unit Chief, Patient Assessment Services Butler Hospital** provided an overview of Rhode Island’s current rates for mental illness and substance abuse- which remain some of the highest in the country. Dr. Szulewski addressed several issues related to Symptoms of illness:

- Lack of resources to care
- Lack of transportation or telephone
- Need for after hours medical care
- Living in supervised housing/shelter

Dr. Szulewski also described some significant barriers as they relate to third party reimbursements and lower rates of reimbursement for mental health services including:

- Restricted medication formularies
- Expensive co-payments
- Lengthy pre-authorizations

Another area of concern that was addressed in the presentation was the significant state resources that have been cut over time at both the federal and state level. Dr. Szulewski highlight several areas impacted over the course of the past 5 years including; cuts to home and community based services for the developmentally disabled population, cuts to child welfare, DCYF and increases in co-payments to RIte Care and RIte Share<sup>10</sup>.

In addition, several recommendations were provided to improve the system including: shifting from crisis management thinking to prevention oriented through medical home models, the creation of 24 hour crisis management facilities and implementing early screening and assessment program. Other areas of recommendation included; advocacy for clients, improved reimbursement by 3<sup>rd</sup> parties and prioritizing mental health in the state’s budget.

**Chairman Jabour** thanked the panelists for their presentations and opened the meeting to all members for a Roundtable Discussion.

**Dr. Goldberg**, Psychiatrist in Chief at RIH asked Dr. Warren a question related to his comment of the “medically uncomplicated/ disproportionate care. He discussed a series of meetings a few years ago in which they discussed alternatives to the emergency department. When these meetings occurred, Dr. Goldberg did not recall any viable options presented.

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<sup>10</sup> The Poverty Institute, 2011 [www.povertyinstitute.org](http://www.povertyinstitute.org)

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**Dr. Warren** responded by saying- yes that is the case. We were very concerned with the limits with the state law that mandates an individual must be taken to an emergency treatment facility (ED) and that would prohibit any alternative facility from being established.

Analyst Note: **RIGL § 23-1.10-10 (c)** *mandates that an individual who is intoxicated or under the influence of substances must be sent to an emergency treatment facility (i.e. emergency room) and evaluated by a licensed physician.*

**Senator Jabour** remarked that this issue is of utmost importance when considering the recent cuts and importance of delivering quality care for those individuals that need services most. Senator Jabour stressed the importance of this issue being part of the budget process and discussed recent legislative attempts to provide prevention and treatment services including drug court and other alternatives.

Dr. Goldberg raised a question and issue in viable options to create alternative facilities or other potentials for appropriately providing services and treating this population.

**Senator Miller** addressed the question by providing an overview of the Senate Commission on Hospitals and the recommendation nine which called for the increased need for behavioral health interventions. There was a bill introduced to modify the language that required a physician to screen an individual at a hospital emergency department room. While this was raised during the Commission process, there were safety concerns and other issues presented at the hearing. There were other issues and complicating factors that needed to be addressed, beyond the licensed healthcare provider issue. Senator Miller asked Butler Hospital about their protocols and whether or no Butler has the ability to take individuals directly from the Police.

**Dr. Szulewski** answered the question by stating that Butler does have the ability to accept patients directly when brought from to their emergency department- but they cannot however accept directly from the rescue runs (due to requirement for medical clearance and screening performed by a licensed physician first).

**Senator Miller** remarked that there are other states that currently have alternative facilities other than the emergency department for this population and although Rhode Island does not currently have the structure, there may be potentials to explore. Senator Miller also discussed his view as a business owner in downtown Providence and witnessing the frequent use of rescue ambulances and police that pick up individuals who are intoxicated and cycling in and out of the emergency department. He remarked that these individuals are brought to the ED, do not receive appropriate treatment including long term treatment for mental health or substance abuse services and end up back at the emergency room department. Senator Miller stated, “it is time for us to interrupt this dysfunctional cycle.”

**Dr. Johnston, Neighborhood Health Plan** used the analogy of “peeling an onion” and the legal requirements as well as more understanding of necessary services needed including appropriate treatment protocols and treatment resources needed to adequately and appropriately address this



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population. In order to look at alternatives, there must be aftercare engagement for clients, setting rigorous standards including exclusionary criteria and protocols for implementation.

**Senator Miller** asked several questions related to those individuals with severe intoxication and what happens if there is a medical issue, mental health issue and what accommodations are made when a bed is not available?

**Dr. Warren** answered by stating the Emergency Department Physicians work closely with the psychiatrists who will either clear or admit a patient for psychiatric issues following a complete psychiatric evaluation. If beds are not available at a treatment facility, patients oftentimes must wait for one to become available.

**Liz Earls, Rhode Island Community Mental Health Organizations** remarked that those with mental health and substance abuse disorders face long wait times for beds in emergency departments, often lingering in the emergency rooms

**Director Stenning, BHDDH** stated that there are several successful initiatives that have been implemented- for example Charter care is beginning to move in the right direction as they start to develop strategies around behavioral health issues. There are barriers that exist including the laws and other factors that are part of the problem. Unlike mental illness- we have a statute to deal with surrounding alcohol and treatment services for those intoxicated individuals.

<p><i>RIGL</i> § 23-1.10 is the RI statute that governs all treatment and procedures for individuals under the influence of substances or alcohol.</p>
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**Nick Zaller, PhD The Miriam Hospital** discussed how many states and cities from across the country including Florida, Cambridge MA, Seattle WA and Oregon have implemented alternative facilities that provide more appropriate care and treatment services for individuals diagnosed with behavioral health issues as an alternative to the emergency department. The State of Oregon has a substance abuse law which allows individuals to be held for up to 48 hours (involuntarily) at a licensed facility. Dr. Zaller remarked that the biggest unknown is the costs and potential savings, but if he were given access to the hospital data and costs, he could run estimates and analyses.

Senator Jabour thanked all of the participants for their contributions and announced the next scheduled hearing for **Wednesday November 30<sup>th</sup> at 2:30 pm**. The panelists for that hearing will include; Deb Florio- DHS, Dr. Mack Johnston- NHP, Commissioner Steven Pare- providence Public Safety and Lt. Corey Jackson- Pawtucket Police.

**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**

**Special Senate Commission to Study Emergency Department  
Diversion**

Notice of Meeting

DATE: Wednesday November 30, 2011

TIME: 2:30 PM

PLACE: Senate Lounge, State House

- 1) Welcome- Senators Paul V. Jabour & Joshua Miller
- 2) Medicaid Reimbursements: Findings, high cost case review Problem – Deb Florio, Department of Human Services
- 3) Mack Johnston, Neighborhood Health Plan- Non Emergent Behavioral Health ED Usage and Health Care Reimbursements
- 4) First responders Role and Response- Commissioner Steve Pare, Providence Public Safety; Lieutenant Cory Jackson, Pawtucket Police
- 5) Roundtable Discussion with members and public members
- 6) Additional Business
- 7) Adjournment

**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**

**Special Senate Commission to Study Emergency Department  
Room Diversion**

**Second Meeting Summary  
November 30, 2011**

**Chairman Paul V. Jabour** welcomed the Commission membership and thanked them all for their participation. Senator Jabour summarized the past meeting of the Commission and described the three common themes from the meeting including; our system’s failure to appropriately and cost effectively treat individuals with non emergent behavioral health issues; the devastating impact to both the individual and the system when budgets cuts undermine services provision; and the importance of examining and changing laws that prevent alternatives to screening and treating non emergent behavioral health issues in locations other than the emergency department. Senator Jabour emphasized the role of commission members in helping both educate the entire group as well as shape the legislative priorities.

**Co-Chairman Joshua Miller** thanked Senator Jabour for his remarks and discussed the importance of the commission in developing concrete legislative priorities that can be acted upon. He stated that last session there was an attempt to amend legislation that would significantly change the law as it relates to the Treatment and services of intoxicated persons and persons incapacitated by alcohol.

23-1.10-1 Intoxicated persons: must be brought *to an approved public treatment facility for **emergency treatment*** (part of the medical service of a general hospital) and *shall be examined by a **licensed physician*** as soon as possible

He shared his goal of meeting of developing concrete recommendations that the Senate can act upon with policy and legislation and that the work of the commission was very important not only in identifying issues but also potential solutions.

**-Deborah Florio, Administrator of Department of Human Services (PowerPoint attached in the addendum)**

Presented a PowerPoint on the state’s Communities of Care Model and Medicaid expenses as they relate to non emergent behavioral health ED usage. Ms. Florio described the Medicaid cost data (million) by year which consists of:

	Medicaid ER Expenses
2005	\$36.2m
2008	\$52.1m
2012 Proj.	\$84.7m

Total Growth: 12.9% per Year

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The Communities of Care Model focused on several different areas of research including; focus groups, examining the issue with key stakeholders, literature reviews and state wide efforts to reduce emergency department usage.

### **KEY OBSERVATIONS, 4+ ER UTILIZERS**

- Substitute for Primary Care
- Young Parents Without Support Networks
- Multi-Provider Utilization (PCP, Pharmacy, Specialists, Prescribers)
- Presence of Complex Chronic Conditions
- Chronic Pain Issues
- Unmet Mental Health and/or Substance Abuse Treatment Needs
- Drug Seeking
- High Users Year-over-Year

#### **-Mack Johnston, Neighborhood Health Plan (PowerPoint attached in the addendum)**

Presented a presentation on the treatment of non medical intoxicated individuals. Dr. Johnston remarked that the newest figures indicate that Rhode Island has the highest rates for drug and alcohol dependence in the country and there are not enough adequate treatment options available for individuals. He proceeded to highlight the importance of changing the state law which requires an individual who is intoxicated to be screened by a licensed physician at a emergency department facility (ED) and discussed how the testimony of the physicians and experts in the room has revealed that this is neither the most cost effective nor best clinical way of treating individuals with substance use disorders. Dr. Johnston referenced the Soros Closing the Addiction Treatment Gap Pilot Project which utilized EMS ETOH (alcohol protocols) for EMTs to medically screen individuals who were “appropriate to divert” to an alternative facility if one were available. Of the 71 discrete individuals- the EMTs appropriately medically screened 70. Dr. Johnston recommended that the Commission look to other models that have been adopted across the country in states such as Oregon, California and Washington that have continuum of care programs to appropriately triage and connect individuals with resources to assist in their treatment. In addition, the Doctor stressed the upcoming expansion of health insurance coverage through the Affordable Care Act (ACA) and urged the commission to consider the Senate’s 2010 hospital commission’s recommendation # 9 which relates to amending the state statute for evaluations in community based settings.

#### **Questions and Answers:**

**-Dr. Warren** inquired about the state’s recent funding through CMS for the health homes grant and how this funding may help support this work moving forward.

**-Deborah Florio, DHS** responded that the funding was pertaining to the Significantly and Severally Persistently Mentally Ill (SSPMI) population but that Director Stenning would be able to answer more specific information as the grant funding was awarded to DBHDDH.

**-Director Stenning, DBHDDH** noted that the health homes model is indeed intended for the SSPMI population and the agency anticipates that there will be an increase in costs initially to identify individuals with complex medical needs and integrated care.

Director Stenning asked Dr. Johnston if his intention of bringing individuals who were under the influence of alcohol included a “non-voluntary” client and how the costs of the facility would be captured.

## SPECIAL SENATE COMMISSION TO STUDY EMERGENCY DEPARTMENT DIVERSION

**-Dr. Johnston** responded by stating that his statement for the population did not include an “involuntary client” and that in order to fully investigate this type of model (it could potentially include the alternative stabilization unit or some other existing structure) but that would need to be fully discussed and determined by the appropriate state agency. In order to thoroughly investigate, there would need to be an examination of research and regulations prior to moving forward. Dr. Johnston asserted that he does believe that an alternative facility could cost up to 1/3 less than utilizing a current emergency department for those without complex medical needs.

**-Dr. Warren** described that protocols are essential in order to determine the appropriate level of care for individuals. At the alternative stabilization unit, medical clearance is required but it is not done by a physician- but rather a medical professional such as an RN or Nurse Practitioner. In order for an alternative center to maintain both costs and quality of care, a non physician is often used at centers.

**-Dale Klatzker, Providence Center** stated that as one of the operators of the alternative stabilization unit in the state I can tell you that there are currently two ways in which an individual can be medically screened; either through the emergency room department or through a Community Health center.

**-Neil Corkery, DATA of RI** asserted that this work is very important but we do not want another Benjamin Rush situation where people are being taken somewhere against their will and potentially lacking appropriate medical or treatment. As a provider I have had a fair amount of experience bringing individuals who are experiencing behavioral health issues and South County Hospital. Many treatment providers will seek medical clearance for individuals prior to seeing them as patients; we do not want this negative connotation with “diversion”. It is essential that we ensure individuals get the medical care that they need and that they are engaged in a continuum of treatment and care.

**-Dr. Mack Johnston** agreed with Mr. Corkery stating that in California where this model exists 26% of individuals are actively engaged in post alternative care following admission to an alternative facility.

**-Lou Gianola, CEO South County Hospital** remarked the need for a change- and inquired with commission members if anyone was familiar with the model in Camden and the population that we are all discussing. He disagreed with the use of the term “non emergent” and does not see the issue as a non emergency.

**-Dr. Warren** stated that the use non emergent refers to those individuals who are not experiencing a true “medical emergency” but perhaps may be intoxicated for a significant portion of their day.

**-Dr. Nick Zaller, the Miriam Hospital** stated that this is not a single issue but more attention and focus should be on a comprehensive approach. This is not a unique problem to Rhode Island- there are at least 10 models from across the country that have examined and implemented the whole aspect involving medical clearance (including researching both liability and medical clearance). This is certainly not about denying medical care to individuals but rather expanding systems, building on existing systems. There is a potential to triage and examine cost savings for alternatives to the emergency room department. Even with the expansion of the affordable care act, my guess is

## **SPECIAL SENATE COMMISSION TO STUDY EMERGENCY DEPARTMENT DIVERSION**

that we will still have a significant number of individuals who may never go into long term treatment- but out of that group we do have the opportunity to impact some and interrupt the dysfunctional system.

**-Commissioner Steven Pare, Providence Public Safety** presented a PowerPoint on the Providence EMS system (included in addendum) The Commissioner described the problem statement as Emergency Medical Service being dispatched to non emergent incidents with no viable alternative other than transport to the ER.

- Commissioner Pare recognized that this is a national problem- RI Cities most effected Providence 244 runs per 1000 residents Newport 241 runs per 1000 residents Pawtucket , CF, Cranston, East Prov. Facing same problem
- Each EMS run costs \$580.00
- 27,459 runs in Providence in 2010
- \$15,962,220.00 cost to city at \$580.00 per run
- The city recovers about 4 million from insurance
- Ten percent are true emergencies (estimated by EMS personnel)
- Most calls are rides to the hospital for non emergency care
- The Providence EMS examined one month of rescue runs for the month of March 2010 for a basic life support (BLS) vehicle and had the following statistics on the type of call for service; 603 BLS runs, 100 per truck. ETOH 183 (Intoxicated), Emotional 56, Medical aid 58, Leg pain 31, Abdominal pain 77, Vomiting 41, Back pain 41, Flu-like-symptoms 39, Weak and dizzy 9.
- Commissioner Pare described the trend on Thursday, Friday and Saturday nights of EMS personnel and “buses” being tied up for ETOH calls which oftentimes mean that true emergency calls are missed.
- In addition to the inability to respond to true emergencies is the impact ton personnel and difficulty in hiring and retaining staff. On any shift EMS personnel respond to 12-15 EMS calls. In addition, in order to deal with the calls that are non emergency in nature, the City must utilize mutual aid of other cities which include 250 rescues from other municipalities.
- Commissioner Pare urged the commission to consider the importance of appropriate diversion and treatment so that it was not further taxing the system and to deliver more appropriate care to individuals, including those who are experiencing true medical emergencies.

**-Detective Lieutenant Cory Jackson, Pawtucket Police Department** presented as an 18 year officer if law enforcement (PowerPoint included in addendum)

- In researching the issue, the Lt. used the dispatch log which included 89,500 (to date 2011).
- Assaults and crimes of violence have decreased 24.3% since 2003 while calls for well being have increased 46.4%. The type of calls have significantly changed over the course of the past 8 years.
- With limited resources, training costs and the change from community policing to a model of response training- it has altered the way that departments conduct police business from more of a focus on public safety and less on public service.
- Lt. Jackson estimated that Pawtucket Police spend and average of 49.2 days dealing with emotional disturbance, well being calls, mental health) @ 30 minutes on average for each call.

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- Lieutenant Jackson described chapter 23-10.1-4 which is the mental health law and concerns with violating individuals' 4<sup>th</sup> amendment rights when taking someone into custody if they are under the influence and refuse. There have been several high profile cases.
- Officers typically receive their only training in the academy and have limited experience and time to make an informed decision.
- Oftentimes police receive significant number of bolo (be on the look out) calls from the hospital describing an individual and requesting that they be brought back to the hospital. This creates significant dilemmas to police when an individual refuses.

### Questions and Answers:

**-Senator Jabour** remarked on the legality and cases from around the country dealing with false imprisonments and naming hospitals as co- defendants. As we look at a variety of laws perhaps we need to also examine the statute for commitment.

**-Director Stenning** stated that RI has one of the most comprehensive medical health statutes in the country- in who, how when to keep someone. There is also a confidential mental health court. He described how DBHDDH has provided trainings and could present to Lt. and the commission if requested.

**-Lou Parente, MedTech Ambulance Service** commented on the discussion to bring individuals to alternative sites and discussed how the EMS is limited in their ability to provide comprehensive medical screening (without lab work and considering liability issues). Off site there are considerations such as cost sharing that would need to be factored in for private ambulance companies when the cost to operate a private ambulance is \$220 for a non emergency while a municipal is around \$400- with Medicaid reimbursing for \$69.00 the remaining cost is on municipalities and/ or individuals.

**-Neil Corkery** expressed concern with the state not having an adequate number of treatment facilities to appropriately treat the population. We would need to consider a more comprehensive system.

**-Senator Miller** asked the Commissions how cities of similar size to Providence are dealing with this issue. How does ones with lower ratios of response calls use best practice policies? Is it possible to work with Department of Health and examine protocols?

**-Commissioner Pare** responded by stating that some cities have examined how to train personnel to ask questions and if they screen that it is not a true emergency, they do not respond with an EMS bus.

Commission members expressed concern with the purpose of the Commission and how to solve these issues.

**-Senator Miller** reiterated that this is about narrowing of the issues to solve legislatively. While there are several areas that can be identified and solved through legislation, there are still areas of practice that need to be identified and improved upon. The Commission members must identify through the moving parts and ability to prioritize issues that can be solved.

**-Dr. Goldberg** inquired about the work of the Soros Project three years ago and the momentum and what has changed or failed to make this work move forward.

**-Dr. Zaller responded** by stating that yes indeed there was and still is a need for legislative changes but that is not the end all be all. Other sites across the country have figured out how to adequately maximize and leverage resources- incorporate housing, detox and sobering centers and deliver quality case management and wrap around services. Several impediments are the current law, funding and lacking public support. These recommended legislative changes are necessary but

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not sufficient; we do need a system to support the population we have all spoken about for the work moving forward.

**-Senator Jabour** remarked the importance and reiterated Dr. Zaller's phrase- what we are talking about is necessary but not sufficient. We must address comprehensive care that is integrated in order to address the issues. The legislative changes we have discussed are a first step.

**-Lou Giancola** asked all of these alternative programs, how did they solve this issue?

**-Senator Miller** stated that we must first identify the legislative priorities and then come up with a sequence for outcomes and implementation- this is far more complicated than one bill. Perhaps we also consider having first responders and doctors/ medical personnel meet to discuss the complexity of these issues. We can examine other states and their models and legislation to examine what can possibly be done.

**-Director Stenning stated** that the clear purpose is critical and the Commission should take small pieces in order to solve some legislatively. This is a global problem and while some individuals may express an interest to enter treatment, others will not. We must examine public policy first and then look at funding. Historically funding has been decreased for this type of initiative, our detox dollars have been impacted- how do we continue to make improvements to the system. The budget is a major factor- as well as housing. There is a model that works- the housing first model is effective. In order to get the most effect- we must address the issue of treatment, jobs and the cost for all services.

**Senator Jabour** thanked all participants for their attendance at the meeting and asked that members set aside 2 hours for the next meeting.



**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**

**Special Senate Commission to Study Emergency Department  
Diversion**

Notice of Meeting

DATE: Wednesday December 14, 2011

TIME: 2:30 PM

PLACE: Senate Lounge, State House

1) Senators Paul V. Jabour & Joshua Miller

Welcome and Introductions

2) Director Craig Stenning, Director Department of Behavioral Healthcare,  
Developmental Disabilities and Hospitals (BHDDH)

3) Current State regulations surrounding ED diversion, role of ambulance advisory board and  
protocols- Department of Health -Jason Rhoades

4) Opportunities- Models in our state Dale Klatzker, CEO Providence Center

5) Roundtable Discussion

Adjournment

**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**

**Special Senate Commission to Study Emergency Department Room  
Diversion**

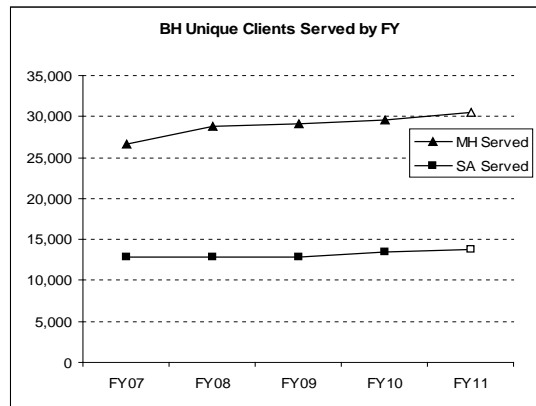
**Third Meeting Summary  
December 14, 2011**

**Chairman Paul V. Jabour** welcomed the Commission membership and thanked them for their commitment to this work. Senator Jabour opened the meeting and invited the first presenter, Director Craig Stenning DBHDDH.

**Director Stenning, Director Behavioral Health Disabilities and Hospitals (BHDDH)** provided a PowerPoint including overview of the agency and the key functions (presentation included in addendum):

- BHDDH has a broad range of responsibilities as the lead state agency for behavioral health, disabilities and hospitals. BHDDH funds and licenses services through community partners.
- Reduction in budget has occurred every year for the last 11 years.
- State and federal law- office recognizes as the Single State Agency for mental health and behavioral health- limits over community hospitals and psych units.

**Demand for Services**



-Agency oversees involuntary law for mental health law (10 days admission) of individuals who meet criteria. Rhode Island has one of the most comprehensive mental health laws in the country for involuntary commitment.

-coordinated responsibilities exist between DOH and BHDDH on the regulatory and licensing pieces for facilities, etc.

The Director provided an outline of specific issues related to behavioral health and emergency department diversion including:

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-short and long term solutions- cost efficient, quality improvements

Specific issue to Non 3rd party insurance (Medicaid and uninsured)

- short term- flow of patients in and out of the system

-State funding is for finite number of slots (tx)

- Long term- reduce demand at hospital level

-Increase sub use, alcohol, #s at CMHC with co-occurring all issues (for screening and service delivery)

Data:

-state wide there has been an increase ED visit increase

Year	Adult Visits	Geriatric Visits	Total Visits	Annual Increase
2005	25,383	2,192	27,575	
2006	28,154	2,580	30,734	11.5%
2007	29,395	2,422	31,817	3.5%
2008	29,811	2,585	32,396	1.8%
2009	32,123	2,787	34,910	7.8%

-BHDDH recently led the way in introducing a 26 bed expansion with Butler Hospital

Goals-to provide treatment early on to reduce substance use.

-Due to Budget reductions, increase in demand for services, ED visits

- Uninsured population 200% Federal Poverty Level (FPL) RI residents-

**Demand for Inpatient Care for Uninsured  
AD**

MISSIONS	2008	2009	2010	2011
PSYCHOSP	808	750	734	892
ERDIVERT	255	640	654	543
<b>TOTAL</b>	<b>1063</b>	<b>1390</b>	<b>1388</b>	<b>1435</b>

Currently two state run funded program for alternatives to ED:

-SSTAR and Providence Center with acute Stabilization Units- BHDDH funds two units; OHHS funds (diversion beds only)

-Detox funding through the state is a separate funding stream that was significantly reduced this past year.

Misnomer:- Note all ED usage and backlog is for the uninsured populations

- Reduction in wait times in ED (for psych beds for uninsured acceptance) Average wait times/ 2008 1 day and 1/4 to 2011 1 day wait time

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**Question:** does it vary for those that are insured? It is worse for 3rd part insurers than for those uninsured or on Medicaid?

**Recommendation-** to transfer the knowledge for the uninsured population to the insured population such as decrease wait times (additional information)

Director: work hard to decrease the 2 tiered system- services for the uninsured in this case can actually be better than for those that are Commercially insured.

Important to deliver comprehensive wrap around housing and employment opportunities- recommendations for improvements to the system in this regard for the commission.

BHDDH conducts a daily review- for open psych beds in the state- wait times, vacant beds, reasons for the vacancy- two staff dedicated.

- facilities section of mental health law- oversee maintenance of patients in psych ward- was a check list/ now ongoing review for licensing staff and behavioral health monitors

Mental health court- district judge court ordered outpatient treatment- convince judge to avoid due process meet monthly with community hospitals

**Issues:**

Clinical changes to system of care- better tx early on-ASUs, access to recovery program (vouchers for housing, benefits, etc)

Contract for state beds within psych facilities, detox unit (was butler, then SSTAR-- now new contract will be with the Providence Center

Project recovery to transform mental health system, health homes model.

**Health Homes Model:**

Changes in psych (single intake system staffed 24 hours), 23 hour observation beds, decrease in wait time for ED (max of 4 hours), more direct decrease of ED use.

Health Homes- major initiative 2nd state nationally- switch in federal match/ each community mental health org. will have a medical component, close relationship with a health center or physician

*Outcomes:* improved care coordination; reduction in preventable ED visits; improvement in management of care for chronic conditions; CMS recognizes mental health as one of issues, reduction in hospital readmissions

*Health Homes is a recent state plan amendment that RI received \$12,171,505 for funding over two years to integrate primary care and behavioral health services and build a person-centered system of care to achieve outcomes for beneficiaries.*

- **Housing:**

Thresholds- only amount in state budget used as a match (for new construction costs)

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- Housing first- one program for potential enhancement/ expansion evaluation- all costs- total per person cost \$22,000 cost to individual for previous year- \$32,000 (\$8,830 per person) savings
- Group homes to multidisciplinary facilities
- ATR for housing (initial down payment, security)
- Sober housing- vacancies exist currently

### **Recommendations:**

increase funding thresholds - housing first model

Harrington hall-transform from a shelter to more stable. Offer employment-first supportive employment opportunities for individuals to transition.

**Jason Rhoades, Chief division of EMS** presented a PowerPoint (included in the addendum)

- how DOH engages and est. regulations pertaining to hospital transports

-2 key documents with rules and regulations

-transportation to non emergency facility- that can happen for inter-facility transfers (not exclusive to 911 services)

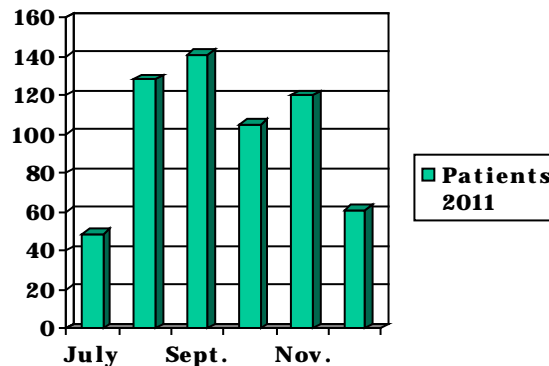
If a pilot needs to be developed- will need approval from DOH direct:

- stand alone protocol

- pre existing protocol (life threatening illness- based on diagnosis in the field protocol- specific medical clearance and criteria that already exists

- strong use of medical contract, quality improvement and assurance

### **Transports to Hospital EDs coded by EMS as Poisoning/Overdose, Alcohol Intoxication**



### **Questions:**

**Dr. Warren** I thought alcohol intoxication was the second most frequent call. This is not backed up by hospital data. Can you break data down by municipality? Yes, preliminary data- but new system end of December will allow (coding is inconsistent)

**Jason Rhoades:** data on patients that have mental health illness (no data yet available)

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**-Dr. Dale Klatzker, Providence Center CEO** presented a PowerPoint on the Providence Center and the numbers as they related to emergency department utilization for emergency department diversion (presentation included in addendum).

- |  |  |
|--|--|
| -high cost, high frequency issues  | -repeat users- 26 individuals w/ more than 5 in 90 days  |
| -complex needs   | -16 in 3 year period   |
| -highest costs, levels of care   | -41 individuals w/ 10 inpatient  |
| -BHDDH data- indigent care (slide)   | -37 individuals with readmissions in 3 year period to detox  |
| -over 70 unique individuals with 10 or more admissions to detox or readmissions to inpatient | *reusing system repeatedly systems:<br>"bouncing, navigating system, services do not communicate- collaborated lack of coordinated care- options are limited |

New vision of care- based on needs of individual- accessible and appropriate services. Individuals connected, long term, self efficacy,

**PROVIDENCE CENTER OVERVIEW OF SERVICES:**

- Patient Centered model- integrated/ not fragmented. appropriate level (not highest level)
- Alternative Stabilization Units in state- alternative to inpatient (Providence and N. Kingstown) 24/7-- recovery, transition back to community (15-16 months) 838 individuals served/ 738 readmits
- 40% referrals- being diverted to unit (before ED or inpatient facility) stepping down to community array of coordinated services statewide for comprehensive needs-
- Increase home based- housing and support services to chronically, mental ill (100 people housed per year)
- Reinforce step down and first responders- for individual needs of population- only necessary care at the
- Providence Center working through coordination of care- RWU (charter care) and St Joes (central intake for all behavioral health issues) - on site tool through utilization and what patients need (opiate addiction- doubled opiate tx- not inappropriate inpatient admit); intoxicated, under influence- need observation and stabilization 23 hour period- as opposed to medical detox or inpatient
- Psych inpatient beds- same # funded past 5 years
- RESPECT model contract(through BHDDH)- starts January 1-2012 1)

## **SPECIAL SENATE COMMISSION TO STUDY EMERGENCY DEPARTMENT DIVERSION**

Home Health Model- CMHC will partner with FQHCs and local hospital to incentivize out of hospital. Requires highest level of care- recovery focus, skills/ whole picture- not one "incident"

### **Recommendations and Next Steps:**

- 1) improve patient centered medical home model\*
- 2) communication of indigent beds statewide- RESPECT
- 3) 1st step- Diversion Policy (legislatively/ regulations) - DOH, state Law
- 4) EMT diversion Policy- appropriate diversion

5) \*Columbia University Suicide Severity Scale- quick to administer (validated tool) CDC has endorsed as a standard- FDA tests with drugs- must use tool, NY uses toll with school system-- standardized tool what triggers behavioral incidents

Home Health Model- CMHC will partner with FQHCs and local hospital to incentivize out of hospital. Requires highest level of care- recovery focus, skills/ whole picture- not one "incident"

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- 1) improve patient centered medical home model\*
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- 4) EMT diversion Policy- appropriate diversion

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Senator Jabour- could this be used for a diversion determination?

Each EMT in the state could potentially administer this instrument as one standardized assessment tool to assess for suicidality risk.

Can rule out other categories- how much time does it take to administer- it takes 1 minute- public domain tool.

**Question:** Detective Cory Jackson- if someone makes mention of suicide- concerned about one bad outcome with screening and not appropriately assessing.

**Dale Klatzker:** Understand concern- but if we continue the way- it's continuing then we're not delivering quality services- liability is always a concern but this would not mean that an individual goes without care, it means there are different options potentially than just an emergency room department.

We need to begin thinking creatively about a package of tools, alternatives that they can go to (other ways of engaging- mental health clinician to ride along, assess the individual- less funding (risk

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management aspect of the process)

**Senator Miller:** Based on contract- how are facilities and services look based on demand? If potential for diversion, by EMTS or other- if you project- your capacity without diversion ability.

**Dale Klatzker-** responded based on BHDDH data- data not comprehensive. Demand for psych inpatient- paid for not what was used. Various components that don't fit- that should fit.

**Senator Miller-** can you meet demand with the allocated resources under contract?

Wider scope- HARI hospital bed capacity 70%- specific to behavioral health/ substance abuse treatment- what is the % of in patient? Data illustrating higher than a 7-% capacity. Vacancies- at any time, etc. getting those to the right place.

How does the Eleanor Slater Hospital function differently?

**Director Stenning:** long term care hospital- must be treated and assessed at a local (not intended for acute care needs) - if they have an admission else where- admission not different. Person may not need a hospital level of care. Slater has a unique profile. Slater is at capacity- number 100% (40 bed capacity)

**Dr. Warren-** -- Gateway is contractor at Roger Williams- it is my understanding that a practitioner cannot talk to person under the influence until their BAC is below legal limit- then evaluation completed. Then search for bed is completed. Numbers are when they begin searching for bed (follow BAC drop).

So this would influence wait times significantly.

**Dale Klatzker** - best solutions as he sees fit-

- 1) use Ed appropriately.
- 2) 23 hour bed- observation. Better approach than sitting in an emergency room department waiting to be seen by a healthcare provider?
- 3) allow the adequate resources

**Questions:**

**Senator Miller-** could the 23 hour program have individuals brought directly to the site- creative transport?

**Dale Klatzker-** ED based service-there are other models in states. But our laws do not currently allow for this- it would have to be changed. We are working through the details of the 23 hour facility and will have more information shortly.

**Dr. Warren-** no public safety vehicle that transports to other sites. Could 23 hour program be funded by EMT programs (less expensive transportation method) as opposed to an EMS vehicle- other than a hospital- to assess and evaluate on street for transport?

**Liz Earls, RICMHO:** I think some of the concerns are the "fixed" costs- unless they take a rescue off the road completely.



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**Commissioner Pare:** We have a total of 6 rescues total in operation today- if we did not transport we could potentially- if we saw the demand for non emergency transports decrease then we may be able to take a rescue off the road.

**Senator Miller-** pilot basis- demonstration project- to show savings for a particular model?

**Dale Klatzker:** Providence Center: 23 hour program will exist within 3-6 months (Providence Center) with Fatima hospital- medical director medical 23 hour bed and the 23 hour psych bed

**Dr Warren** questioned the nature of the 23 hour observation and if it would actually divert individuals? Dr. Warren asserted that it does not actually get to the issue of diversion and complex needs of individual- if held for 23 hours/ not in an ED. But they will return back to the ED. Could 23 hour be based outside of an ED- dr. warren it will not reduce costs

**Senator Miller-** can that 23 hour take place out of an Emergency room department? If it is in psych-readmitted back to the psych.

**Senator Jabour-** There are several models that utilize a involuntary hold for individuals who are under the influence of substances or intoxicated. As I understand the state of FL has a true diversion model with an alternative facility that they utilize.

**SPECIAL SENATE COMMISSION  
TO STUDY EMERGENCY DEPARTMENT DIVERSION**

**Special Senate Commission to Study Emergency Department Diversion**

**DATE:** Wednesday January 11, 2012

**TIME:** 2:30 PM

**PLACE:** Senate Lounge, State House

**Agenda:**

**1) Senators Paul V. Jabour & Joshua Miller  
Welcome and Introductions**

**2) Director Wilfred Labiosa, CASPAR Inc. *Presentation of Cambridge MA Center***

**3) Roundtable Discussion**

**4) Update on draft report and final meeting**

**Adjournment**

No Public Testimony will be taken at this time.

For further information, please call: Caitlin Thomas-Henkel, Deputy Policy Director, Senate Policy Office 276-5551

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## Special Senate Commission to Study Emergency Department Room Diversion

Fourth Meeting Summary (not intended as official minutes) – January 11, 2012

**Chairman Paul V. Jabour** welcomed the Commission membership and thanked them all for their participation. Senator Jabour summarized the past meeting of the Commission and Senator Jabour emphasized the role of commission members in helping both educate the entire group as well as shape the legislative priorities.

**Wilfred Labiosa**, Director of the Cambridge and Somerville Program for Alcoholism and Drug Rehabilitation program (CASPAR, Inc) presented a Power Point on the center's how it works to prevent unnecessary emergency room use and steer patients with behavioral health care problems toward more appropriate and effective treatment. The following summarizes Mr. Labiosa presentation:



The CASPAR emergency Services shelter program has been in operation since 1979, operating 365 days a year 24 hours a day as collaboration between MIT and the City of Cambridge. EMTs and Police officers have the ability to transport individuals directly to the center, based upon extensive training and screening of appropriateness. The center employs 23 full time employees. Clients enter the system and are assigned a unique identifier- used for records in our system. In addition, CASPAR has an extensive outreach component in which staff receive trained in best practice interventions and protocols and operate a van service- directly tied to the EMS dispatch system to transport individuals to the center when deemed appropriate.

*Unlike RI General Laws, Massachusetts General Laws do not expressly state that individuals under the influence of alcohol or substances to be transported to an emergency treatment facility (hospital) and seen by a licensed clinician.*

The CASPAR Emergency Services Shelter operates under a patient centered, harm reduction model and the following encompass the services that the center provides:

- Individualized Treatment Planning, Case Management & Counseling
- Medical Triage Services provided in-house
- Food & Bedding 24/7 to 110+ clients
  - 21PC(case management) clients

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- 20 ACCESS clients
- 69 emergency shelter clients

**Roundtable Discussion:**

**-Commissioner Pare:** How do you actively engage police in this work?

**-Mr. Labiosa:** The police were tired of continually picking up individuals who were actively under the influence of alcohol or substances and cycling in and out of the emergency room department. We worked to train them and have made the process in transporting and delivering individuals simple so that they can fill out one form upon intake. We actually have a very positive response from police in making their jobs easier.

**-Commissioner Pare** What are your sources of funding?

We have a variety of funding sources- but the MA Bureau of Substance Abuse Services funds us for a total of \$900,000 per year and we also have a variety of private funders and donors that fund our program annually.

**-Commissioner Pare:** What is your process for involuntarily committing individuals?

We do not commit individuals- almost all of the individuals who are brought to the center are on a voluntary basis. In the rare case (I would estimate less than 1%) the courts can authorize the commitment of an individual.

**-Dr. Goldberg-** can you please speak to the prevalence of co-morbid psychiatric issues in the population at the shelter? How do you manage medications and complex medical issues? I would estimate that of the population of clients, most have co-morbid diagnosis- over 60%. We work in collaboration with the Cambridge Health Alliance (CHALANCE) that has the ability to deliver medical services in conjunction with our center. CHALANCE has a medical team including a psychiatrist on staff and we actively manage clients medications and see patients on a drop in basis.

**-Dr. Otis Warren-** do you have the ability to bill for Medicaid and/or Medicare for the emergency services or van transports? No- we do not have the ability to bill either through the emergency services shelter, nor the van service due to the regulations.

*Can you please tell us about your liability coverage and your legal team?* We have a very high liability coverage- which is actually subsidized in part by MIT since we are located on the MIT campus. We have an agreement to cost share the liability premium. We have one attorney that works for CASPAR, including the emergency services program, and I can tell you that we have not had a law suit in 10 years. If I had to estimate the percentage of individuals considered “highest risk” I would say around 4%.

*Who licenses your shelter in Massachusetts?* Our emergency services shelter is not licensed- the actual unit- that is. The ACCESS program, kitchen and other adjacent units are all licensed- but the shelter is not.

**-Neil Corkery, DATA of RI:** Can you please tell me how you evaluate success? What is your outcome data and relapse rate? We use the ASI and psychosocial assessment when individuals enter the facility. In addition, we take a baseline, 6 month assessment and one again at one year. We evaluate each client’s success in a variety of ways including their

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treatment, recovery process, housing status and other factors. Our relapse rate is around 18-20%. I have that data at my office and would be happy to share it with you following this meeting. In addition, the City of Cambridge has data that they publish each year that shows their emergency department costs have decreased and since the program has been operational, the hospitals have not reported any losses.

**-Senator Miller:** what do clients who choose to stay do during the day? We provide comprehensive case management, transportation to other treatment programs or supportive services, offer computer classes, psychosocial groups during the day. If clients choose to stay, they do not have to enter into a “lottery” for a nighttime stay.

**-Senator Jabour:** Director Stenning has highlighted the importance of housing and employment as keys to success with those struggling with addiction and recovery. Can you please tell us what your agency is doing in these two areas?

**-Mr. Labiosa:** We have an EAP program in our center which assists individuals who may have CORI issues, resume building for the gaps in employment and an intensive coaching program that graduates 80 individuals each year. We have formed partnerships with businesses such as Dunkin Donuts, Christmas Tree Shop and other organizations that train our clients during the day and often times will hire following the program. We have established partnerships in the community that assist CASPAR and the clients we serve.

**-Senator Miller-** *You mention funders and partnerships- can you please tell us what that means to be a “partner” what level of commitment?* We have an established agreement with all of our partners that they will attend at a minimum quarterly meetings of our agency to discuss issues, progress and other factors as they relate to CASPAR. All agencies also sign a MOU agreeing to this as well as support- in terms of in kind resources, training, funding our other levels of commitment. These partnerships are long standing- close to 30 years- and the agencies are extremely supportive.

**-Senator Miller-** to me it seems essential that if we were to establish a similar program, we would need to have a true commitment from our public safety, hospitals and health insurers in order to develop a successful model. Director Stenning spoke about the new contract that the Providence Center has with BHDDH to deliver detox and other supportive services- I would think that perhaps that contract should include a missing component- outreach and alternative transportation.

**-Director Stenning-** that’s something that we can look at- but the services this agency is referencing, we already have many of the components in the state already.

**-Senator Miller-** perhaps, but the outreach and alternative transport is missing.

**-Liz Earls, RICMHO-** we have done quite a bit in RI with peer navigators and training and components. I agree with the director and believe that out state does have quite a few of these programs in place.

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**-Senator Jabour:** The Cambridge Program appears to have a limited budget to serve a population of 500,000 people in the Cambridge- Somerville geographic area. They spend \$2.4 million on alternative transportation and an emergency services shelter- while the City of Providence spends close to \$16,000,000 on EMS transports alone. It seems to me that if we can establish some partnerships and commitments, we may be able to set up a similar model.

**-Mack Johnston, NHP-** can you please discuss any other formal contracts that you may have with the MA corrections?

**-Mr. Labiosa-** Suffolk County jail is far outside of our catchment area- we do not currently have a prison or correctional facility that is located within our geographic area.

**-Rick Jacobsen, HHS-** you discussed the inability to bill for Medicaid- but do you have the insurance status for all of those that enter the facility?

**-Mr. Labiosa:** we do collect some information on insurance status- especially when clients are enrolled in our ACCESS program. Massachusetts passed the ACA a few years ago, so many individuals are enrolled in Medicaid but I could get you those numbers if you're interested.

**-Dr. Shea-** I noticed that you do not have a detox co-located in the facility. How do you manage those clients that are seeking detox?

**-Mr. Labiosa-** we have MOU agreements with agencies that are contracted through BSAS (state agency) to deliver detox services and we will transport those individuals.

**-Senator Miller-** I have heard the one component that we do not have is the alternative transportation and outreach. The ability to divert individuals with behavioral health issues utilizing a comprehensive outreach method and then alternative transportation (to EMS) is key to this issue.

**-Senator Jabour:** I agree with my counterpart, I think that to make this happen we need partnerships to be established that can commit to funding this as well as the transportation piece. We will be issuing the final report with recommendations and findings next week for your comments and feedback. This has been a collaborative process- we welcome all stakeholders to comments and suggestions on the final report, please feel free to contact Caitlin Thomas-Henkel, our policy staffer.

Next meeting- Wednesday January 25, 2012 2:30pm

**Special Senate Commission to Study Emergency Department Diversion**

**DATE:** Wednesday January 25, 2012

**TIME:** 2:30 PM

**PLACE:** Senate Lounge, State House

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**Agenda:**

- 1) Welcome- Senators Paul V. Jabour & Joshua Miller**
- 2) Review of draft commission report**
- 3) Roundtable discussion**
- 4) Public testimony**
- 5) Additional Business**
- 6) Adjournment**

**Special Senate Commission to Study Emergency Department  
Room Diversion**

**Fifth Meeting Summary** (not intended as official minutes) – January 25, 2012  
Senator Jabour opened the meeting and thanked all of the commission members for their dedication to this effort and the work. The Senator then referenced the draft report before

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commission members and the purpose of the hearing today which is to review the report findings and recommendations for review and feedback.

Senator Miller presented an overview of the recommendations and findings and discussed the importance of hearing back from commission members regarding concerns, questions or clarification of any aspect of the report.

Senator Jabour then welcomed Dr. Brian Zink- Chief of Emergency Medicine at Rhode Island and The Miriam Hospitals, Chair Department of Emergency Medicine. Dr. Zink thanked the senators and commission members for the important work of the commission and the series of recommendations and findings as established in the draft report. Dr. Zink discussed his concern and efforts particular to this issue over the past 6 years in Rhode Island and the constant revolving door of clients under the influence of substances or alcohol and the lack of delivering quality care in an emergency room department. He described the efforts to address this issue with the Soros- Closing the Addiction Treatment Gap and others involved in the effort. Dr. Zink pointed out a critical fact- that no one wants to be a chronic alcoholic and that 6-8 cities from across the country have made an investment in operating alternative centers with significant outcomes. As Dr. Zink and his staff see some individuals 100-150 times a year- this greatly reduces their quality of life as well as life expectancy to an estimate of 2 years. Dr. Zink encouraged members to move forward with this critical work.

Senator Jabour thanked Dr. Goldberg and then opened the comments to all members with any feedback on the report.

### Roundtable:

**Dr. Goldberg** expressed his support with recommendations 1,2, 3 and 6 – but emphasized that the resource issue identified in #3 should not be explicit to the Community Mental Health Organizations (CMHO) in the state. On addition, Dr. Goldberg remarked that the idea of using a validated screening tool is a great idea but a recent journal article highlighted that the Columbia Suicide Assessment Scale should not be used for universal populations, but rather selective indicated populations as a tool- not a specific predictive instrument of suicidal behavior.

**-Senator Jabour** also agreed with Dr. Goldberg that recommendation #6 pertaining to supportive housing is a critical support that is important for individuals struggling with addiction.

**-Director Stenning** called attention to recommendation # 3 specific to Community Mental Health Organizations and through Health Homes Medicaid enhanced funding, to assist with funding an alternative program. The director stated that the health homes enhanced Medicaid funding has strict eligibility criteria that was selected by the state to include; individuals with two (2) chronic medical issues, one of which includes a mental illness (SPMI). The funding cannot be used to fund an alternative program, but perhaps if the state pursues a second state plan amendment there may be the potential- but that is uncertain and based upon strict Medicaid regulations. Director Stenning also called the commission's attention to a memo circulated by BHDDD which outlines concerns with the draft legislation- specifically highlighting concerns of interchanging behavioral health and the intoxication- as it will conflict with the mental health



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law as well as the importance of not making change in the existing statute- 23-1.10-1 *Treatment and services of intoxicated persons and persons incapacitated by alcohol*. The director's memo instead suggested making a new section of law pertaining to the pilot program within 23-1.

*Note- the draft legislation that was referenced is still a working document and is under review by legal council.*

**-Senator Miller** as the former chair of the hospital commission last session- in which there was legislation introduced that pertained to 23-1- the intoxicated statute, I must emphasize how important it is that we modify the statute as it relates to mandating individuals be brought to an ED. In Rhode Island we have an abundance of positive programs and services for individuals with behavioral health and substance use disorders, but I keep stating that in order to address the alternative program, we must make changes in the existing statute dealing with transportation.

**-Dale Klatzker, CEO Providence Center** I keep thinking that we must address this issue comprehensively and divert or interrupt the cycle. In order to achieve better outcomes we must not just look at the indigent population- we must consider all payors. This issue impacts all of those with and without insurance- Blue Cross, United, NHP- we may want to consider how all of those entities may be involved in assisting with the funding for this system. What is ironic is that people assume that private insurance provides the most generous coverage for those with behavioral health and substance use disorders- which is not true. I think we consider a model for all payors.

Director Stenning We have a two tier system- more available to those on Medicaid than the insured- the financing challenges are there.

**-Senator Miller** perhaps we want to consider some legislative language that could compel the health plans to cover some portion of the pilot program?

**-Dr. Goldberg-** when you consider the individuals who present at the ED with acute substance intoxication or under the influence- I would estimate that close to 25% have private insurance. I would concur that it is worth at least investigating the possibility of all payors.

**-Senator Jabour-** well if we consider how the system is fragmented- perhaps we need to mandate the better coordination of services and discuss how to co-locate more services and the transportation piece.

**-Dr. Goldberg-** I agree that our system is fragmented but I would issue a word of caution from mandating such a component. We could create inadvertent consequences with payors across multiple sites- the bill could create more fragmentation.

**-Mack Johnston, NHP** As an insurer I want to reiterate our commitment to this issue. The idea here is to create better care- and there is a legitimate business argument that can be made for the model of an alternative program. Cities from across the country have shown that an upfront

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investment pays off. We would have to examine what Medicaid will and will not pay for- but we're definitely on board.

**-Lt. Jackson-** I like the idea of an assessment<sup>0</sup> but with the limited training that law enforcement receive- I have concern with asking police to act like a clinician. It would be great to receive training and have a mentor. In Cambridge they're successful with the police bringing individuals to the alternative program- I would like to find out more about their training and retraining that they receive.

**-Dr. Warren** I think that the community outreach piece is key- having first responders work with someone who is trained and a mentor so that there are 2 levels of assessing an individual. It is important this is not a one time decision.

**Public testimony:**

**-Deb O'Brien-** Providence Center I want to mention that there are effective models for law enforcement dealing with high end users that enter the system. The outreach piece is key- I also want to mention that we have fund that when dealing with clients who have or present with suicidality, they often threaten but in the clinical community we are not using a common language to assess. The importance of having common language and follow up to ask the right questions to assess is critical.

**Senator Jabour-** I think that we also must consider who we educate the community and that many of these individuals are seen out in the community at non profits and agencies and that the staff must know how to deal with them.

**Dr. Warren-** I think it is important that we consider how the current EMS system is establish with 911 and dispatch and how this program would operate. Thinking about how the training and component would work- similar to how Cambridge models theirs is essential.

**-Senator Jabour-** we will be incorporating your changes and recommendations in the final document and I believe having one final meeting for the final report. Thank you for all your time.