
UNIVERSITY OF
GEORGIA
Carl Vinson
Institute of Government

# ERET Transportation Study

## Executive Summary

January 6, 2023

Commissioned by the Governor's Office of Health Strategy and Coordination

Governor's Office of
PLANNING AND BUDGET
THE STATE OF GEORGIA

# OFFICE OF HEALTH STRATEGY AND COORDINATION

January 6, 2023

Dear Governor Kemp and Members of the Georgia General Assembly,

In my role as Director of the Office of Health Strategy and Coordination (OHSC), I am pleased to submit this report on the transport of individuals to and from emergency receiving, evaluation, and treatment facilities (ERET). This report was developed by OHSC pursuant to O.C.G.A. § 31- 53-3 and the requirements established through House Bill 1013 passed in 2022.

OHSC's work on this transport study began with the effective date of House Bill 1013 on July 1, 2022, and OHSC contracted with UGA's Carl Vinson Institute of Government (Institute) for its development. This report includes the results of a six-week study conducted by the Institute. Of the licensed ERETs, 48 tracked and reported admissions and discharge data and the method of transport used. The study found that numerous transportation methods were used for individuals in crisis. Ambulances, friends and family, law enforcement, and agency vehicles were the most common methods of transport to and from ERETs. The study also evaluated the cost of each transport type based on distance and time.

In addition to collecting data from ERETs, the report includes research conducted on mental health crisis transport systems from states around the Southeast and examines existing programs in Tennessee and Virginia that are meant to help better coordinate transportation of these individuals. The report also examines Georgia's bed coordination efforts and includes recommendations on steps the state can take to improve those efforts.

The scope of this study was defined by HB 1013 to investigate how persons experiencing a mental health crisis are transported to and from ERETs. As a result, transport data to emergency departments or emergency receiving facilities (ERF) that are not licensed as ERETs was not collected. It is important to note that not all individuals who suffer a mental health crisis will be initially transported to an ERET facility. Many will be taken to an emergency department first by sheriffs, family and friends or other means and stabilized before being transported to an ERET facility. For example, this report does not capture cases where a sheriff transports an individual to an emergency department. However, the report does capture an ambulance transport that is used for subsequent transport to an ERET.

A future study that would include a full assessment of mental health crisis transportation to healthcare facilities regardless of ERET classification would address these limitations.

Based on this study, I wanted to highlight some important considerations:

1. Consider ways to shift the number of transports by ambulance to a lower cost alternative. The data shows that the most common method of transport to an ERET is by ambulance which is the most expensive option. Consider ways to use other transportation options to lower the cost to the state and other healthcare providers.

2. Develop methods to collect transportation data through administrative and billing systems and processes. A custom data collection instrument was used to do this study because the data required was not collected in existing intake or discharge administrative or billing systems.

3. Consider a future study that includes transports to all healthcare facilities (ERFs). A follow-up study that provides a longer data collection period and includes transport to ERFs (hospitals that are not ERETs) would provide a more complete picture of the mental health transportation network.

4. Further study grant programs in other states that help offset law enforcement transportation costs. The report provides a scan of how other states in the southeastern United States address the transport of individuals with mental illness. A deeper analysis of the grant program in Tennessee may be helpful in developing policy options for Georgia.

5. With a potential increase in on-site issuance of 1013 Orders now possible under HB 1013, sheriff departments may no longer need to have the person in crisis first evaluated at an emergency department and can instead choose to go directly to a BHCC or CSU. Therefore, law enforcement should be encouraged to utilize the bed registry maintained by DBHDD and accessible to law enforcement through GCAL to find open beds for their transports. Further, local law enforcement and other transport providers should consider prioritizing transport to ERETs instead of general hospital emergency rooms. This will cut out wasted time and get patients to the appropriate healthcare setting sooner.

6. Encourage wider ERET participation in the Bed Registry. A more complete bed registry of not only the BHCC and CSU available beds, but also beds maintained by private providers, would give law enforcement and hospitals (ERFs) more information on where they can place a patient.

7. Consider options for "holding" or "reserving" a bed for 1013 Order transports. This is especially helpful when a sheriff is driving a patient a long distance for an available bed to an ERET facility.

8. Encourage DBHDD to work with GCAL and the Georgia Coordinating Center (GCC) on bed coordination and consider any necessary upgrades or improvements to GCAL technology to improve bed availability information.

While there are limitations in this report, it ultimately better illustrates the scale and variety of resources used in mental health crisis transportation. It is our hope that this report can be used to help inform decision-making when examining methods to improve crisis transportation in Georgia. If you have any questions, please do not hesitate to reach out to me.

Sincerely,

Grant Thomas
Director
Georgia Office of Health Strategy and Coordination

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## Introduction and Background

This report is responsive to a request by the Governor's Office of Health Strategy and Coordination (OHSC) to research the transportation of persons to and from Emergency Receiving, Evaluation, and Treatment facilities (ERETs) in Georgia. The need for this study stems from a requirement in the "Georgia Mental Health Parity Act" (HB 1013) passed and signed into law in 2022. Pursuant to O.C.G.A. § 31-53-3, OHSC is instructed to "conduct a survey or study on the transport of individuals to and from emergency receiving, evaluation, and treatment facilities pursuant to Chapters 3 and 7 of Title 37. Such survey or study shall identify what method of transport is used in each county of the state, such as the sheriff, a law enforcement agency, a private nonemergency transport provider, or an ambulance service."

The study consists of three parts. Part I of the report directly addresses the requirements under HB 1013. Part II presents data on transport requirements for individuals experiencing a mental health crisis and state funding for this transport in nine other Southern states. Part III discusses the challenges and opportunities with coordinating bed availability and placement for Georgia patients in need of impatient treatment (i.e., bed coordination). Together, the three parts present a set of wide-ranging information that begins to clarify the challenges and opportunities facing the state in addressing this complex service challenge.

As the State of Georgia has transitioned from focusing on institutionalizing individuals with severe mental illness to a community-based care model, a need has arisen to occasionally transport people in crisis so they can receive immediate mental health care. Treatment occurs at ERETs, which are specifically licensed medical facilities that have the capacity to serve this population. ERETs are further classified by the types of care they can provide. These are Behavioral Health Crisis Centers (BHCC) which can offer both temporary (5 – 7 days) inpatient and outpatient treatment and are open to the public 24/7 for walk-in assistance; Crisis Stabilization Units (CSU) which only provide temporary (5 -7 days) inpatient treatment to individuals who are determined to need this high level of care; and hospitals that provide inpatient psychiatric stabilization such a Grady Memorial Hospital and Appling Healthcare System. Sheriff Departments play a critical role in transporting persons to ERETs as the law requires them[1] to assist persons pursuant to a 1013 certificate (1013 Order) issued by a physician or by court order authorizing the transport of a person in need of an emergency evaluation.[2]

## Part I: ERET Transportation

This study's findings come from data collected by 48 ERETs located across the state, for a total participation rate of 72.7% (66 ERETs in the total sample).[3] Of the participating ERETs, 26 were BHCCs or CSUs and 22 were hospitals. Institute researchers collected data over a six-week period beginning on August 29 and continuing until October 9, 2022.[4] The data for admissions and discharges should be considered as separate datasets as the patients in one are not the same as those in the other. The data instruments the ERETs used included data points for both admissions and discharges.

For admissions, the data collected included:

- Date the patient was admitted.
- Method of transport taking the person in crisis to the ERET.
- County of transport origination.
- Length of time the patient waited to begin the admission process at the ERET.
- Whether the patient was taken to the ERET under a 1013 Order.
- Whether the patient was an adult or a minor.

The discharge data collection instrument included the following data points:

- Date the patient was discharged.
- Method of transport patient used to leave the ERET.
- County destination for patient transport.
- Patient's length of stay at the ERET.
- Whether the patient was transferred to a state psychiatric hospital.
- Whether the patient was discharged with a 1013 Order.[5]
- Whether the patient was an adult or a minor.

The study also includes the estimated costs to transport patients in the sample. Researchers based the calculations on a cost per mile and/or hour for each method of transport from the county centerpoint of transport origination (destination) to (from) the ERET. Several methods of transport also include a base cost. The cost rate for each transportation method was determined from consultations with experts familiar with the different methods. To avoid underestimating costs, a minimum transport time of 30 minutes was applied to transportation methods that included an hourly cost but no base cost. The research did not calculate cost estimates for Family/Friends and Self-Transport.

Typical for applied research, the data has limitations. Foremost, relying only on ERETs to collect transportation data excludes transports to emergency receiving facilities (ERFs), such as general hospitals without an ERET designation. By limiting the study to only ERETs as specified by HB

1013, many transports, including those by law enforcement or self-transport, were likely not counted. Additionally, because of the limited time to collect data, these results should not be extrapolated beyond the sample. Additional data that includes a longer time frame for transports and all ERFs would offer a more thorough understanding of the transportation of people in mental health crisis across the state.

## FINDINGS: ADMISSION DATA

From the 46 ERETs that submitted admission data, 38.6% of admissions were to BHCCs/CSUs, and 61.4% were to hospitals, reflecting the capacity of these two types of institutions. The total number of patients in the dataset equaled 6,759. Grady Hospital in Atlanta had the most admissions, with 1,077 or 15.9% of the total, while West Central Georgia Regional Hospital had the least at five.

In order to better understand who was transported and where the trip originated, the data collection instrument included three descriptive variables:

1. Was the individual arriving pursuant to a 1013 Order?
2. Was the individual an adult or a minor?
3. What was the county where the transport originated?

Approximately the same number of individuals arrived at the ERETs under a 1013 Order (53.3%) as without one (46.7%). Our sample had a much higher proportion of adults (81.3%, n = 5,443) than minors (18.7%, n = 1,256). Individuals were transported from 150 counties out of 159 counties in the state. The number of trips originating from the counties varied widely, generally reflecting their relative overall populations. Fulton County had the most transports, with 17.6% (1,047 transports) of the total, while 48 counties had five or fewer transports during the data collection period. The rate of transports per 100,000 also showed a wide range (334.7 per 100,000 to 3.48 per 100,000), with some of the counties having the highest rates also being rural counties.

The ERETs reported 13 different methods of transport, including one medical flight, to their facilities. The most common transport methods were ambulance (32.3%) and family or friends (27.6%). Law enforcement, i.e., police and sheriff departments, transported 16.5% of people in crisis. Several staff members from the ERETs stated that many patients were transported from ERFs where they had been initially evaluated.

Table 1. Method of Transport to ERETs

| Transportation Method | Frequency | Percent of Total |
|---|---|---|
| Ambulance | 2,174 | 32.3% |
| Family/Friends | 1,859 | 27.6% |
| Sheriff | 585 | 8.7% |
| Police | 522 | 7.8% |
| Self-Transport | 508 | 7.5% |
| Nonemergency Medical Transport | 389 | 5.8% |
| Agency-Owned Vehicle | 323 | 4.8% |
| Nonemergency Medical Transport-Simple | 213 | 3.2% |
| Internal Facility Transfer | 45 | 0.7% |
| Other-institution Owned Vehicle | 45 | 0.7% |
| Co-Responder Unit | 28 | 0.4% |
| Public Transportation | 26 | 0.4% |
| Taxi or Rideshare Service | 13 | 0.2% |
| **Total[1]** | **6,730** | **100.1%** |

Note: Missing data: 28 cases. See appendix for definitions. Sum exceeds 100% due to rounding.
1. Excludes medical flights, as there was only one case.

Patterns of transport emerged from the descriptive variables discussed previously. Ambulances were more likely to bring patients to hospitals (88.8%) than to BHCCs/CSUs (11.2%), while agency-owned vehicles (86.4%) and other-institution owned vehicles (80.0%), were more likely to transport patients to BHCCs/CSUs. For individuals coming to an ERET under a 1013 Order, the most common type of transport was an ambulance (42.4%), while approximately half of the individuals without a 1013 Order arrived with a family member or friend (50.8%). Overall, the data did not present striking differences in the transportation methods between adults and minors. Minors were less likely to be transported by law enforcement than adults; however, they had a higher percentage of transports via a medical vehicle, either ambulances or non-emergency medical transport (NEMT).

ERETs recorded the time medical transport and law enforcement personnel had to wait with the individuals they had transported until the latter began the admissions process. This question was asked in order to better understand the resources these groups must expend beyond the actual transport. The data showed that a small percentage of these official personnel must wait an extended period of time, with 78% waiting less than 15 minutes and 4.3% waiting over two

hours. Nearly 10% of minors (9.3%) had to wait over two hours, compared to 3.1% of adults. Less than 1% of all patients arriving under a 1013 Order had to wait over two hours. Likewise, the distance travelled for transport was not lengthy. Data collected on miles traveled indicated almost half of the reported admissions had trips of less than 15 miles in distance and that 75% of trips were less than 50 miles one way.

The estimated transport cost is the last piece of information presented as part of the Admission Findings. The most expensive transportation method was ambulance, with an average cost of nearly $1,200 per trip. The large aggregate cost was due to the higher per-trip costs plus it was the most frequently utilized form of transportation to ERETs. Agency-owned transport, co-responder, other-institution owned vehicle, and police all had a relatively similar average per trip costs. Sheriff per trip average cost was larger than police because of the former's longer mileage for trips in the dataset.

**Table 2. Estimated Cost of Transportation to ERETs**

| Transportation Method | 6-week Aggregate Cost | Average Cost per Trip | Median Cost |
|---|---|---|---|
| Agency-Owned Vehicle[1] | $6,979 | $21.61 | $14.44 |
| Ambulance | $2,074,556 | $1,188.86 | $799.99 |
| Co-Responder | $529 | $18.91 | $17.87 |
| Non-Emergency Owned Vehicle | $153,446 | $385.54 | $336.76 |
| Non-Emergency Owned Vehicle-Simple | $69,749 | $333.72 | $301.50 |
| Other-institution Owned Vehicle | $933 | $21.21 | $14.44 |
| Police | $13,644 | $28.13 | $24.19 |
| Public Transportation | $38 | $2.50 | $2.50 |
| Sheriff | $26,716 | $45.67 | $29.66 |
| Taxi/Rideshare | $400 | $30.74 | $7.86 |

Note: Missing data: 28 cases
1. Combines cost data for three agency-related methods of transport: Agency-Owned Vehicle, Department of Humans Services Contracted Transport, and Employee Vehicle.

## FINDINGS: DISCHARGE DATA

Data on discharges were collected during the same six-week time period. This data is in a separate data set from the admissions data. A total of 47 ERETs completed or partially completed the discharge data instrument, and of these, 43% were located within the Atlanta Metropolitan Area and 57% outside the area. Additionally, BHCCs/CSUs discharged 34.0% of all patients in the dataset, while hospitals discharged the remaining 66%. Like the admission data, Grady hospital reported the most discharges, with 18.1% of all 5,934 reported discharged patients.

The discharge data instrument included the same descriptive variables as the admission data instrument. For discharged patients, 55.1% had a 1013 Order, and 44.9% did not. Of all the discharged patients in the dataset,[6] 82.1% were adults, and 17.9% were minors. Adults and minors were discharged from hospitals and BHCCs/CSUs at approximately the same rate. The dataset included the counties where patients were travelling to when discharged, indicating where they may permanently reside. Patients were transported to 149 out of the 159 counties across the state, and 32.9%[7] specifically went to counties within the Atlanta Metropolitan Area. Additionally, 4.1%[8] of the discharged people went to a state psychiatric hospital. The data also included 30 patients whose destination at discharge was out of state.[9]

Family and friends were the most common method of transportation at discharge. Other non-medical forms of transport (i.e., agency-owned vehicles, other-institution owned vehicles, NEMT-Simple) were also prevalent. This finding appears appropriate as the patients were released because they had been stabilized and ambulances should not be needed.

**Table 3. Method of Transport from ERETs**

| Transportation Method | Frequency | Percent of Total |
|---|---|---|
| Agency-Owned Vehicle[1] | 554 | 13.4% |
| Ambulance | 434 | 10.5% |
| Co-Responder Unit | 1 | 0.0% |
| Family/Friends | 1,826 | 44.2% |
| Internal Facility Transfer | 206 | 5.0% |
| Non-Emergency Medical Transport | 28 | 0.7% |
| Non-Emergency Medical Transport-Simple | 345 | 8.4% |
| Other-Institution Owned Vehicle | 112 | 2.7% |
| Police | 13 | 0.3% |
| Public Transportation | 79 | 1.9% |
| Self-Transport | 102 | 2.5% |
| Sheriff | 240 | 5.8% |
| Taxi or Rideshare Service | 191 | 4.6% |
| **Total** | **4,131** | **100.0%** |

Note: Missing data: 1,803 cases. Grady Memorial. Wellstar Atlanta Medical Center, and Wellstar Cobb Hospital ED did not report transportation discharge data.
1. Combines the transport categories: agency-owned vehicle, DHS contracted provider, and employee vehicle as these are all funded by the ERET

Differences emerge for transportation when the data is separated by ERET type. BHCCs/CSUs were far more likely to utilize agency-owned vehicles, other-institution owned vehicles, and public transportation to transport patients from their facilities as opposed to hospitals. Family and friends transported patients from BHCCs/CSUs in somewhat greater numbers than from

hospitals. Finally, hospitals were far more likely to have patients transported via ambulance, NEMT-Simple vehicles, law enforcement, and taxis or rideshare services.

Generally, patients discharged after having a 1013 Order relied on the same transportation methods as patients who did not have one. One exception was transport by ambulance, as those patients with a 1013 Order used them more than patients who did not have a 1013 order (16.2% and 1.6%, respectively). Patients without a 1013 Order were also more likely to be transferred to another department within an ERET (9.3%) than patients with a 1013 Order (2.1%).

There were also substantial differences in the transportation methods at discharge between adults and minors. While adults (36.0%) relied heavily on family or friends to leave the ERET, minors were far more likely to have this form of transport (69.9%). Likewise, nearly twice as many minors (16.2%) were transported by ambulance than adults (8.7%). Adults used agency-owned vehicles (17.1%) far more than minors (1.8%) as well as law enforcement (adults, 7.3% and minors, 2.3%).

The data collected at discharge also included a question about the length of stay. Nearly half the patients stayed at an ERET for over 48 hours, reflecting the dataset's high number of BHCCs, CSUs, and CSU units in hospitals.

In aggregate, the most expensive form of transport was an ambulance, followed by a NEMT-Simple. However, on an average per-trip basis, NEMT-Simple is slightly over one-tenth the cost of an ambulance. Taxi/Rideshare had a relatively expensive cost per trip due to many very long rides (i.e., over 100 miles), which is why the median cost per trip is so much lower than the average cost per trip. Finally, agency-owned vehicles were used relatively frequently (see Table 3), and their cost per trip was far lower than for the medical transportation methods.

Table 4. Estimated Cost of Transportation at Discharge

| Transportation Method | 6-week Aggregate Cost | Average Cost per Trip | Median Cost |
|---|---|---|---|
| Agency-Owned Vehicle[1] | $12,630 | $23.30 | $14.44 |
| Ambulance | $626,600 | $1,467.45 | $1,267.98 |
| Co-Responder | $36 | $35.85 | $35.85 |
| Non-Emergency Medical Transport | $18,623 | $532.09 | $563.90 |
| Non-Emergency Medical Transport-Simple | $52,379 | $151.82 | $120.14 |
| Other-Institution Owned Vehicle | $2,775 | $25.45 | $14.44 |
| Police | $1,120 | $93.30 | $74.89 |
| Public Transportation | $193 | $2.50 | $2.50 |
| Sheriff | $10,879 | $45.33 | $26.23 |
| Taxi/Rideshare | $22,357 | $119.56 | $67.06 |

Note: Missing data:1,925 cases
1. Combines cost data for three agency-funded forms of transport: Agency-Owned Vehicle, Department of Humans Services Contracted Transport, and Employee Vehicle.

## CONSIDERATIONS

The following considerations for Part I are offered based on the data collected about ERET transports for admissions and discharges and taking into consideration the study's limitations.

1. **Shift ERET transports from ambulance service to other lower cost options**. The sample data collected for this study indicate a high number of transports by ambulance to ERETs which is one of the most expensive transport methods. Consider ways to use other transportation options to lower the cost to the state and other healthcare providers.

2. **Study transports to and from ERFs**. The scope of this study as outlined in HB 1013 focused on the transport of individuals to and from an ERET. A follow-up study that provides a longer data collection period and includes transport to and from ERFs (Hospitals that are not ERETs) would provide a more complete picture of the mental health transportation network.

3. **Collect more data from ERFs on mental health admissions and discharges**.

    a. Gather more information from ERFs on the number of admissions related to mental illness as the sole diagnosis versus co-occurring problems such as substance abuse, physical injury, or physical health problem. Understanding the proportion of cases that present at the emergency department that are solely mental health related will provide needed information on potential opportunities to redirect these cases directly to an ERET.

b. To more fully understand the flow of persons to and from ERFs, more data is needed about ERF admissions that are mental health related. Knowing how many people need inpatient residential treatment (24 hours) in the emergency department, how many are admitted to the hospital, how many are discharged to go home from the ERF, and how may are transferred to an ERET would greatly inform future decisions.

4. **Develop ways to collect transportation data through administrative and billing systems and processes.** A custom data collection instrument was used to do this study because the data required was not collected in existing intake or discharge administrative or billing systems.

## Part II: Multi-State Review of Emergency Mental Health Transport

This section presents the statutory requirements in Georgia and nine[10] other southeastern states for persons in mental health crisis being involuntarily transported. In Georgia, when a physician has executed a Form 1013, a peace officer must make diligent efforts to take a person into custody and transport them to the nearest ERF for an emergency evaluation.[11]A county court can also issue an order commanding a peace officer to take such person into custody and deliver them for examination at the nearest ERF within the county in which they are found.[12] In the other states, a local law enforcement agency has the ultimate legal responsibility to transport these individuals from an evaluation center to another medical facility that can treat them for an extended period of time. Three states (North Carolina, Texas, and Virginia) make provision for non-law enforcement transport under certain conditions. However, the majority of state governments do not provide funding to local governments in order to offset transportation-related costs. Statutes do authorize local governing authorities to recoup these costs if the individual transported is not indigent, such as through billing a third-party insurer. In contrast to this majority, the states of Tennessee and Virginia have established programs that either directly offset the costs associated with these transport obligations to law enforcement through grants or reduce the burden on law enforcement through third-party transportation programs.

### TENNESSEE

With input from the legislature, the governor's office, several state agencies, and multiple stakeholder groups, the State of Tennessee amended its state code[13] in 2019 to create a grant program that supports sheriffs performing mental health transports. Tennessee sheriffs are mandated to transport "people with mental illness who are determined to be a danger to themselves and in need of restraint or vehicular security."[14] In order to receive the grant, sheriff departments must adhere to several requirements aimed toward accountability and protection

of the individuals being transported. The requirements apply whether a sheriff directly or a contracted transport agency transports people in crisis. The grant has evolved slightly over the last three years to create a minimum, annual funding level ($25,000) in order to reduce administrative burdens on sheriffs' departments and thus increase program participation. Some sheriffs' departments from less populated counties have begun contracting with larger departments for the latter to perform the mental health transports on their behalf with the larger departments receiving the grant funding and undertaking all administrative mandates. Currently, sheriffs in 44 of Tennessee's 95 counties are participating in the grant program.[15]

## VIRGINIA

Virginia also sought to relieve the burden on their sheriffs' departments through a new statewide non-emergency medical transport program. Virginia law requires sheriffs' departments to transport individuals who have met the criteria to have a Temporary Detention Order (TDO) from a mental health evaluation center to a treatment facility. Additionally, evaluation centers only permit patients to stay for several hours so sheriffs have a limited time frame to perform their duties. Like Tennessee, this new program was developed in partnership with elected officials, state agencies, the state sheriffs' association, and mental health advocates to meet the dual goals of providing better service to patients while relieving law enforcement of transportation responsibilities. After a successful pilot in 2018, the state implemented a new mental health transport program that relied on a single, third-party vendor (i.e., NEMT company) to transport persons in crisis when appropriate (i.e., the person was non-violent). Sheriff departments would still transport patients who were not suitable candidates for NEMT transport. Because of the time limitations to transport patients to a treatment facility and other performance benchmarks, the contractor established several NEMT stations around the state that are manned 24/7 in order to be available when needed. The program was appropriated $6,429,216 for FY 2023[16]. The original goal was to have 50% of all transports performed by NEMTs but the median monthly utilization rate from July 2020 to June 2021 was only 10%.[17] Overcoming this challenge is the primary goal and support for the program remains widespread. Two options being considered to increase the utilization of NEMTs are first, reorganizing the statewide system into a regional approach and second, allowing some restraint of patients by NEMTs (currently none is allowed) along with the kinds of patients they are permitted to transport.[18]

## CONSIDERATIONS

The following consideration is based on the information collected for Part II of the report on policies of nine southeastern states regarding mental health transportation.

**Review transportation programs from other states.** Learn from other state programs to develop policy options for Georgia on ways to fund the transport of mentally ill persons in crisis. The report provides a scan of how other states in the southeastern United States address the transport of individuals with mental illness. A deeper analysis of the grant program in Tennessee may be helpful in developing policy options for Georgia as it complements our state's diverse population, service needs, and large number of counties.

### CONCLUSION

These two cases are similar in that they both promote using alternative transport (i.e., NEMTs) for patients in crisis; yet, they approached it differently. Tennessee adopted a local control model, while Virginia implemented a statewide contract. Because mental health patients in Virginia can only remain at an evaluation center for a limited time period, the need to create a network of NEMT transporters likely influenced the need for a state-administered program. However, mental health stakeholders in Tennessee and Virginia continue to support relying on NEMTs to assist law enforcement in transporting persons experiencing mental health crises.

## Part III: Bed Coordination

Part III briefly examines the challenges facing the State of Georgia to efficiently coordinate the demand for available beds in inpatient treatment, with a focus specifically on state-managed facilities (BHCCs, CSUs, and the state psychiatric hospitals). While the Georgia Crisis and Access Line (GCAL) provides several emergency-related services for Georgians, its Bed Registry and Bed Board serve as the linchpins for bed coordination. With the Bed Registry, GCAL staff can see the number of beds available at each ERET for patients at any given time and then can direct law enforcement to transport persons in crisis to the closest open bed. ERETs not managed by the state are not mandated to participate in the Bed Registry. Emergency receiving facilities (ERFs) and county jails use the Bed Board to post their patients and inmates, respectively, which need inpatient care. When an ERET has a bed available, it will look at the Bed Board for the most convenient patient and then contact the facility holding the person in crisis t to begin the transport process. The system's effectiveness is highly dependent on timely information and the state has established protocols that are fairly successful in ensuring all parties regularly update their information.

State-managed ERETs with inpatient treatment are intended for individuals who have no payer source, such as private insurance or Medicaid.[19] As of October 5, 2022, there were 1,553 beds at state-managed ERETs, and 88.5% were operational. Note that beds may not be available at a facility due to staffing shortages and/or COVID19 protocols. Sixty percent of all beds were at

state hospitals, which only serve adults. Less than 5% (4.8%) of all state-managed ERET beds are dedicated to children and adolescents.

Ensuring every person in crisis has timely access to inpatient treatment close to their location is a difficult feat for several reasons. The first is determining the appropriate balance between ensuring a sufficient but not excessive supply of inpatient treatment, as the latter will result in a poor allocation of the state's limited resources. The constant fluctuation for bed demand partly creates this challenge. The number and location of people needing inpatient treatment varies daily with only regional consistencies, such as the Atlanta Metropolitan Area will always need more beds than rural areas. Sparsely populated areas create their own challenge as demand does not warrant a large number of beds, so individuals living there who require a bed may need to travel longer distances. The data in Part I explained that sheriffs' departments have the responsibility for transporting persons under a 1013 Order; yet, deputies rarely call the Bed Registry to learn where a bed is available.[20] Instead, they often transport persons to ERFs for evaluation or go directly to the nearest BHCC or CSU if they have developed relationships with staff at the facility. However, there have been instances[21] when a sheriff department called the Bed Registry, and the deputy transported their charge based on the information given, only to find that the designated ERET no longer had an available bed. Finally, because state-funded ERETs prioritize their services to those without insurance, individuals who come to these facilities (i.e., to BHCCs) needing inpatient care but have private insurance are usually referred or transported to another ERET. BHCC staff must then coordinate this transportation which diverts time from their patients.

## CONSIDERATIONS

Based on the research conducted, the following considerations are offered as means to improve overall bed coordination and collaboration between ERETs with transport stakeholders and other emergency receiving facilities.

1. **Create a working group**. Because of the challenges and resulting frustrations with bed coordination, DBHDD may want to regularly convene a group of stakeholders to evaluate how to address ongoing issues as a team. The goal of this working group would be to collectively develop solutions so that every member understands their responsibilities to improve the process. Possible discussion topics may include opportunities for improving GCAL technology and functionality and how GCAL may be able to partner and coordinate with the Georgia Coordinating Center (GCC).

2. **Increasing law enforcement's use of the bed registry**. With a potential increase in on-site issuance of 1013 Orders now possible under HB 1013, sheriff departments may no longer need to have the person in crisis first evaluated at an emergency department and

can instead go directly to a BHCC or CSU. Therefore, law enforcement should be encouraged to utilize the bed registry through GCAL to find open beds for their transports.

Currently, DBHDD regional offices provide presentations and engage with local law enforcement departments to inform peace officers about GCAL and the bed registry. DBHDD could enhance its communication and outreach efforts to local law enforcement and transport providers across the state to make them aware of GCAL's Bed Registry and Bed Board. Also, DBHDD may want to also explore working with the Peace Officer Standards and Training Council or the Georgia Public Safety Training Center to inform new officers about the bed registry. Information about the bed registry could be included in crisis intervention training as well.

3. **Encourage wider ERET participation in the bed registry**. Expanding ERET participation in the bed registry is one of DBHDD's long-term objectives. To create a comprehensive bed registry system, ERETs not managed by DBHDD would need to participate. The Governor's Office of Health Coordination and Strategy and DBHDD may be able to research and explore possible incentives for ERETs to actively participate in the registry.

4. **Research an option to reserve a bed for a 1013 transport**. Protocols could be established, in partnership with law enforcement associations, for peace officers to reserve a bed at an ERET when transporting a person long distance under a 1013 Order and after they have contacted GCAL for a recommendation. GCAL would issue the peace officer a recommendation, and then GCAL and DBHDD could potentially reserve a bed for an individual at that recommended facility for a limited amount of time. Research would be needed to determine the best way for such a system to work. This situation would need to be very limited because of the high demand for beds, such as for transports over 100 miles in one direction. Ultimately, a bed reservation process would need to be managed by GCAL.

5. **Utilize data for strategic planning**. DBHDD collects a tremendous amount of critical data about persons in mental health crisis and utilizes it for strategic decision making. Utilizing this data, the Department could perform periodic reviews of ERETs and compare the length of time individuals at emergency departments and jails wait to be transferred to an ERET for assistance. It may be useful to integrate this information with bed availability at ERETs.

## Conclusion

This report fulfills the requirements for a study of the transport of persons experiencing a mental health crisis to and from ERET facilities under HB 1013. Ambulances, family and friends, and law enforcement are the three most common ways that persons experiencing a mental health crisis reach an ERET facility. At discharge, family and friends are the dominant form of transport, followed by agency-owned vehicles. The dataset included several descriptive variables that allowed for more nuanced analyses of the transportation data. Cost estimates for the different forms of transport showed that ambulances are the most expensive on a per-trip basis and that less expensive methods, such as NEMTs, may be viable alternatives in some situations.

The data, though informative, must be caveated due to the limited time frame for data collection. A study with a longer time horizon could provide more definitive answers regarding transportation to ERETs. Likewise, a study that includes all ERFs, not just ERETs, would enable a more accurate representation of transportation methods. Expanding the research to include ERF's would be particularly beneficial to sheriffs' departments that transport people in crisis to emergency departments. Ultimately, the goal of this more extensive study would be to present a more holistic picture of transportation for persons in mental health crisis

Part II of the report scans the transportation policies of nine southeastern states regarding mental health transportation. Case studies on innovative programs in Tennessee and Virginia highlight two different approaches states have taken to try and address the cost and burden of transporting persons with mental illness who are in crisis. Tennessee offers a grant program to fund sheriffs performing transports with certain rules and reporting requirements. Virginia developed a strategy to shift transports of non-violent patients to nonemergency medical transport (NEMT) through a statewide contract with an NEMT provider.

Part III of the report summarizes research and considerations related to ERET bed coordination. Currently, only state-funded beds are part of the GCAL bed coordination system. Priority for state-funded beds is given to persons in crisis without a payer source. More coordination and communication between GCAL and its stakeholders may help address common challenges. If there were a central clearinghouse of all available ERET beds (public and private) it could make it easier on sheriffs and hospital staff looking for an available bed. The data in Part I of the report indicate that about 14 percent of admission trips are over 100 miles. In these rare cases, having an assurance that a bed is available when the ambulance or sheriff arrives would reduce frustration. Law enforcement benefits from general awareness of how the ERET system works and how to utilize the services at GCAL in responding and assisting a person having a mental health crisis.

This study provides state leaders insights into the transport of persons experiencing a mental health crisis to and from ERETs. The final assessment is that persons in crisis rely on a variety of methods to reach and leave ERETs. Ambulances, friends and family, law enforcement, and agency vehicles are the most common methods of transport to and from ERETs.

# Appendix A

## Definitions of Transportation Methods to ERETs

**Ambulance.** This category comprises transport via a medical ambulance that may be owned by a local government, hospital, or private company. Ambulance was coded as the form of transport regardless of whether the situation was an "emergency" or not, as long as the vehicle was an ambulance with medical equipment and staffed with medical professionals, such as paramedics or emergency medical technicians (EMT).

**Agency-Owned Vehicle.** This category includes any form of transport paid by the ERET. The vehicles could include a sedan or van owned by the ERET and driven by staff, employees driving their personal vehicles and reimbursed by the ERET, or a contracted vehicle that is not an ambulance, nonemergency medical transport, or taxi/rideshare service.

**Co-Responder Unit.** The patient is transported by personnel whose organization(s) have a law enforcement and mental health professional partnership.

**Family/Friends.** The patient is transported by a family member or friend.

**Internal Facility Transfer.** The patient arrived at the unit from another department located at the same facility, such as transferring from an emergency department to a crisis stabilization unit.

**Nonemergency Medical Transport (NEMT).** The patient is transported by a vehicle with some specialized equipment but not an ambulance, and the driver has some specialized training in mental health, such as crisis intervention training and first aid but is not a certified EMT.

**Nonemergency Medical Transport-Simple (NEMT-Simple).** The patient is transported by a vehicle, typically a small bus without specialized medical equipment beyond a wheelchair lift. The driver lacks specialized training in mental health.

**Other-institution Owned Vehicle.** The patient is transported by a vehicle not owned or funded by the ERET, and the admissions staff did not classify the vehicle as an ambulance or nonemergency medical transport. This category would include a sedan or van driven by nonmedical personnel.

**Police.** The patient arrives in a police patrol vehicle driven by a police officer.

**Public Transportation.** The patient arrives unaccompanied by a family or friend via public transportation such a bus or MARTA.

**Self-Transport.** A person either walks to the facility or drives themselves to the facility.

**Sheriff.** This category includes transport via any type of vehicle owned by a sheriff department and driven by a sheriff department employee. This could be an unmarked vehicle.

**Taxi or Rideshare Service.** The patient arrives unaccompanied by a family or friend in a taxi or rideshare vehicle such as an Uber or Lyft.

# Endnotes

[1] O.C.G.A. § 7-3-101.
[2] A 1013 is a certificate, issued either by a physician or court order that authorizes the transport of an individual to an emergency receiving facility for an emergency evaluation by a physician to determine if such individual is mentally ill and requires involuntary treatment. Following admission at a facility, the patient must be discharged within 48 hours of his admission unless the examining physician or psychologist concludes that there is reason to believe that the patient may be a mentally ill person requiring involuntary treatment and executes another certificate, known as a 1014, to that effect within such time.
[3] Not all ERETs fully completed the data instrument for the entire data collection period. Missing data in the represents these partial responses.
[4] A handful of ERETs began data collection one week later in order to ensure staff has sufficient training to complete the data collection instruments. Data collection ended on October 16, 2022 for these facilities.
[5] 1013 Order could have been issued prior to admission or while at the facility.
[6] Missing data equals 3 cases.
[7] Missing data equals 803 cases. Neither Wellstar Atlanta Emergency Department nor Wellstar Cobb Emergency Department collected data on where patients were discharged, substantially reducing the number of cases to report. Counts patients transported out-of-state at discharge as outside Atlanta Metropolitan Area
[8] Missing data equals 240 cases. The "No" category, includes 168 patients from state's four psychiatric hospitals.
[9] Cases recorded as: Alabama (9), Florida (2), North Carolina (1), Out-of-State (7), South Carolina (8), and Tennessee (3)
[10] Alabama, Arkansas, Florida, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia
[11] O.C.G.A. 37-3-41(a)
[12] (O.C.G.A. 37-3-41(b)
[13] Tenn. Code Ann. § 33-6-406
[14] Tenn. Code Ann. § 33-6-901.
[15] Video interview with Jeremiah Morton on October 27, 2022.
[16] 2022 Special Session I Virginia Acts of Assembly.
[17] *Alternative Transportation Program Annual Report – November 8, 2021.*
[18] Video Interview with Gail Paysour on October 20, 2022.
[19] A person in mental health crisis with Medicaid could be served at a BHCC/ CSU when there are no available facilities that accept the individual and/ or their payer source.
[20] Video interview with Dawn Peel, DBHDD; Melissa Sperbeck, DBHDD; and Ashley Fielding, DBHDD, November 3, 2022
[21] This research could not verify the extent to which this situation occurs.