

Health Impact Review of HB 1864
Transporting patients by ambulance to facilities other than emergency departments
(2025 Legislative Session)

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Staff contact:

Cait Lang-Perez (she/her)

Phone: (360) 628-7342

Email: Cait.Lang-Perez@sboh.wa.gov

Website: <https://sboh.wa.gov/health-impact-reviews>



Full review

The full Health Impact Review report is available at:

<https://sboh.wa.gov/sites/default/files/2025-02/HIR-2025-04-HB1864.pdf>

Acknowledgements

We would like to thank the key informants who provided consultation and technical support during this Health Impact Review.

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Executive Summary
HB 1864, Transporting patients by ambulance to facilities other than emergency departments (2025 Legislative Session)

Evidence indicates that HB 1864 would likely result in Department of Health (DOH) conducting rulemaking; some regional Emergency Medical Services (EMS) & Trauma Care (TC) councils adopting ambulance transport procedures for facilities other than emergency departments (EDs) into regional EMS-TC Patient Care Procedures; and some medical program directors and local EMS-TC councils developing a county operating procedure, writing a patient care protocol, and identifying facilities to accept referrals; which may result in some patients being transferred to facilities other than EDs. It is not well researched how provisions may impact health outcomes.

BILL INFORMATION

Sponsors: Thomas, Griffey, Doglio, Parshley, Rule, Fosse, Timmons, Farivar, Reed, Springer, Ramel, Nance, Cortes, Simmons, Peterson, Macri, Street, Salahuddin, Obras, Pollet, Zahn, Hill

Summary of Bill:

- Updates [RCW 18.73.280](#) to allow an ambulance service to transport patients to a facility other than an emergency department (ED), such as an urgent care clinic, a mental health facility, or a substance use disorder program, as authorized in regional emergency medical services (EMS) and trauma care (TC) plans under [RCW 70.168.100](#).
- Requires a health carrier offering a health plan issued or renewed on or after January 1, 2026, to provide coverage for ground ambulance transport to a facility other than an ED, such as an urgent care clinic.
- Directs Health Care Authority (HCA) to update reimbursement methodology for ambulance services when transporting a person enrolled in Apple Health (Medicaid) to include transport to a facility other than an ED.
- Updates the definition of “patient care procedures” in [Chapter 70.168 RCW](#) (Statewide Trauma Care System) to include a substance use disorder program or other nonemergency department facility, such as an urgent care clinic.
- Reenacts and amends [RCW 18.71.210](#) to include transport of patients to facilities other than EDs, such as urgent care clinics and substance use disorder programs.

HEALTH IMPACT REVIEW

Summary of Findings:

This Health Impact Review found the following evidence for HB 1864:

- **Informed assumption** that allowing an ambulance service to transport patients to a facility other than an ED, as authorized in RCW 70.168.100, would likely result in the Washington State Department of Health (DOH) conducting rulemaking to enable ambulance services to

transport patients to facilities other than EDs. This informed assumption is based on the implementation of previous changes to state law, other DOH guidance, and information from key informants.

- **Informed assumption** that DOH conducting rulemaking to enable ambulance services to transport patients to facilities other than EDs would likely result in some regional EMS-TC councils adopting ambulance transport procedures for facilities other than EDs into regional EMS-TC Patient Care Procedures (PCPs). This informed assumption is based on previous DOH guidance, a review of regional EMS-TC councils' Fiscal Years (FY) 2024-2025 Strategic Plans and PCPs, and information from key informants.
- **Informed assumption** that some regional EMS-TC councils adopting ambulance transport procedures for facilities other than EDs into regional EMS-TC PCPs would likely result in some medical program directors (MPDs) and local EMS-TC councils developing a county operating procedure (COP), writing a patient care protocol (protocol), and identifying facilities other than EDs to accept referrals. This informed assumption is based on implementation of previous transport procedures, information from key informants, and information from published literature.
- **A fair amount of evidence** that some MPDs and local EMS-TC councils developing a COP, writing a protocol, and identifying facilities other than EDs to accept referrals may result in transport of some patients to facilities other than EDs.
- **Not well researched** how transport of some patients to facilities other than EDs may impact health outcomes.

Additional Considerations includes discussion of reimbursement for ambulance services and costs for patients.

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State ([RCW 43.20.285](#)). For the purpose of this review “health disparities” have been defined as differences in disease, death, and other adverse health conditions that exist between populations ([RCW 43.20.025](#)). Differences in health conditions are not intrinsic to a population; rather, inequities are related to social determinants (access to healthcare, economic stability, racism, etc.). This document provides summaries of the evidence analyzed by State Board of Health’s Health Impact Review staff during the Health Impact Review of House Bill 1864 ([HB 1864](#)).

Health Impact Review staff analyzed the content of HB 1864 and created a logic model visually depicting the pathway between bill provisions, social determinants, and health outcomes and equity. The logic model reflects the pathway with the greatest amount and strongest quality of evidence. The logic model is presented both in text and through a flowchart (Figure 1).

We conducted an objective review of published literature for each step in the logic model pathway using databases including PubMed, Google Scholar, and University of Washington Libraries. The annotated references are only a representation of the evidence and provide examples of current research. In some cases, only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore, the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question and are referenced multiple times.

We consulted with people who have content and context expertise about the provisions and potential impacts of the bill. The primary intent of key informant interviews is to ensure staff interpret the bill correctly, accurately portray the pathway to health and equity, and understand different viewpoints, challenges, and impacts of the bill. In total, we spoke with 21 key informant interviewees, including: 8 state agency staff with expertise in the EMS system, ground ambulance transport, and health coverage; 7 local EMS agency staff; 5 people with experience serving on or working with regional and local EMS-TC councils; and 1 alternate facility staff member. More information about key informants and detailed methods is available upon request.

We evaluated evidence using set criteria and determined a strength-of-evidence for each step in the pathway. The logic model includes information on the strength-of-evidence. The strength-of-evidence ratings are summarized as:

- **Very strong evidence:** There is a very large body of robust, published evidence and some qualitative primary research with all or almost all evidence supporting the association. There is consensus between all data sources and types, indicating that the premise is well accepted by the scientific community.
- **Strong evidence:** There is a large body of published evidence and some qualitative primary research with the majority of evidence supporting the association, though some sources may have less robust study design or execution. There is consensus between data sources and types.

- **A fair amount of evidence:** There is some published evidence and some qualitative primary research with the majority of evidence supporting the association. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Expert opinion:** There is limited or no published evidence; however, rigorous qualitative primary research is available supporting the association, with an attempt to include viewpoints from multiple types of informants. There is consensus among the majority of informants.
- **Informed assumption:** There is limited or no published evidence; however, some qualitative primary research is available. Rigorous qualitative primary research was not possible due to time or other constraints. There is consensus among the majority of informants.
- **No association:** There is some published evidence and some qualitative primary research with the majority of evidence supporting no association or no relationship. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Not well researched:** There is limited or no published evidence and limited or no qualitative primary research and the body of evidence was primarily descriptive in nature and unable to assess association or has inconsistent or mixed findings, with some supporting the association, some disagreeing, and some finding no connection. There is a lack of consensus between data sources and types.
- **Unclear:** There is a lack of consensus between data sources and types, and the directionality of the association is ambiguous due to potential unintended consequences or other variables.

This review was requested during legislative session and was therefore subject to the 10-day turnaround required by law. This review was subject to time constraints, which influenced the scope of work for this review.

Analysis of HB 1864 and the Scientific Evidence

Summary of relevant background information

Federal law

- An “Emergency Department” (ED) refers to a hospital department or facility that: 1) provides emergency care if a person walks in without an appointment; 2) has signs posted saying it provides emergency care; and 3) receives Medicare funds.¹
- In 1973, U.S. Congress (Congress) passed the Emergency Medical Services System Act (Public Law 93-154), directing funds to develop regional emergency medical services (EMS) systems.²
- In 1985, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA),³ effectively eliminating federal funding for EMS.² The EMS grant program was folded into the original legislation for the federal Preventive Health and Health Services (PHHS) Block Grant.^{2,4} PHHS Block Grant is administered by the U.S. Centers for Disease Control and Prevention (CDC), and funding is provided to all 50 states.⁴ The majority of PHHS Block Grant funding is flexible and may be used by states to fund prevention and health promotion programs, and some states have used PHHS Block Grant funding to support EMS programs.⁴
- In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.⁵ Specifically, “EMTALA requires that hospitals with [EDs] provide medical examinations and treatment for emergency medical conditions [...] regardless of a patient’s ability to pay.”⁶ The law puts specific obligations on Medicare-participating hospitals that offer emergency services,⁷ which includes most U.S. hospitals.¹ While Veterans Affairs (VA) and military hospitals are exempt from EMTALA, the Veterans Health Administration (VHA) complies with the intent of EMTALA requirements.⁸ The law gives everyone in the U.S. regardless of insurance status, ability to pay, race, color, national origin, sex, religion, disability, age, or citizenship status, the following protections:
 - An appropriate medical screening exam to check for an emergency medical condition, and if the patient has one,
 - Treatment until the emergency medical condition is stabilized, meaning the condition is unlikely to get materially worse, or
 - If necessary, an appropriate transfer to another hospital with the staff and facilities available to stabilize the emergency medical condition.¹ Before transferring the patient, the hospital must explain the benefits and risks to the patient.¹
 - EMTALA does not include ground ambulance services.⁶

Washington State emergency medical services

- In Washington State law:
 - Ambulance means a ground vehicle or aircraft designed and used to transport people who are ill and injured; provide personnel, facilities and equipment to treat patients before and during transport; and licensed in accordance with [RCW 18.73.140](#).⁹

- Ground ambulance means a ground vehicle designed and used to transport people who are ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation.⁹
 - Air ambulance means a helicopter or airplane designed and used to provide transportation for people who are ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation.⁹
- Emergency ambulance transport means the act of transporting a person by use of an ambulance during which a patient receives needed EMS during transport to an appropriate medical facility.^{9,10}
- An ambulance transport provider is licensed under RCW 18.73.140 and bills and receives patient care revenue from the provision of ground emergency ambulance transports.¹⁰
 - This does not include a provider that is owned or operated by the state, cities, counties, fire protection districts, regional fire protection service authorities, port districts, public hospital districts, community services districts, health care districts, federally recognized Indian tribes, or any unit of government as defined in 42 C.F.R. Sec. 433.50.¹⁰
- Prehospital means emergency medical care or transportation rendered to patients prior to hospital admission or during interfacility transfer by licensed ambulance or aid service under [Chapter 18.73 RCW](#), by personnel certified to provide emergency medical care under Chapters [18.71](#) and [18.73 RCW](#), or by facilities providing level V trauma care services as provided for in [Chapter 70.168 RCW](#).⁹
- Advanced life support (ALS) means invasive EMS requiring advanced medical treatment skills as defined by Chapter 18.71 RCW.¹¹
- Basic life support (BLS) means noninvasive EMS requiring basic medical treatment skills as defined in Chapter 18.73 RCW.¹¹

Washington State law and policies

- The Washington EMS and Trauma Act of 1990 created the Washington State Department of Health's (DOH) Office of Emergency Medical Services (EMS) and Trauma System, the EMS & Trauma Care Steering Committee (EMS-TC Steering Committee), and the 8 EMS & Trauma Care (EMS-TC) Regions.¹²
 - The EMS-TC Steering Committee provides guidance and direction to DOH in its development of the trauma system.¹³ The EMS-TC Steering Committee is made up of 30 members, appointed by the Secretary of Health, representing surgeons and physicians, hospitals, prehospital providers, firefighters, local health departments, consumers, and other affected groups.¹³
 - The 8 EMS-TC Regions are made up of local and regional councils. Regional EMS-TC councils are responsible for duties outlined in RCW 70.168.100 including developing: the regional plan, regional Patient Care Procedures (PCPs), prevention and public education programs to address regional injury problems, etc.¹⁴

- The 8 regional EMS-TC councils include Central Region, East Region, North Region, North Central Region, Northwest Region, South Central Region, Southwest Region, and West Region.¹⁵
 - Each regional plan includes in-depth implementation guidelines and goals. The plan addresses issues relating to demographics, education and training, communication, quality assurance, prevention and public education, prehospital services, acute and rehabilitation facilities, and includes PCPs.¹⁴
 - PCPs define how each regional EMS-TC system operates. Regional councils develop PCPs with input from county medical program directors (MPDs) and other system partners.² All regional plans have PCPs to address basic system functions, and the EMS-TC Steering Committee and DOH review PCPs included as part of each approved regional plan.²
- In 2015, the Legislature passed Substitute House Bill 1721 ([Chapter 157, Laws of 2015](#)) allowing EMS ambulances and aid services to transport patients (voluntarily) from the field (i.e., a non-medical location where EMS responds to a 911 call) to mental health or chemical dependent services.²
- Effective January 1, 2020, [Chapter 48.49 RCW](#) (Balance Billing Protection Act) protects consumers from balance billing (also called “surprise” billing) practices in situations where patients do not have an opportunity to choose their healthcare provider, including EMS, air ambulance services, and non-emergency services provided at in-network hospitals or ambulatory surgery centers.⁶
 - In March 2022, air ambulance transportation and emergency behavioral health services were added to Chapter 48.49 RCW to align with the federal No Surprises Act.⁶
 - In October 2023, the Office of the Insurance Commissioner (OIC) submitted a report to the Legislature with recommendations to prevent balance billing for ground ambulance services.⁶ One of the recommendations was to require commercial health plans to cover ground ambulance transport to behavioral health facilities as well as mandate health coverage for emergency transportation to alternative destinations.⁶
 - In March 2024, the Governor signed Substitute Senate Bill (SSB) 5986 ([Chapter 218, Laws of 2024](#)) into law, which prohibits out-of-network ambulance companies from sending a “balance bill” to patients who receive emergency medical treatment at the scene or are transported to an appropriate emergency service provider’s location, among other provisions.¹⁶ Effective January 1, 2025:
 - A nonparticipating ground ambulance services organization may not balance bill an enrollee of a health plan for covered ground ambulance services (i.e., rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient to an appropriate emergency services provider; and ground ambulance transport between emergency services providers, emergency services providers and medical facilities, and between medical facilities when the services are medically

necessary) which are provided by 1 or more ground ambulance vehicles designed for this purpose.¹⁶

- A health carrier must provide coverage for ground ambulance transports to behavioral health emergency services providers for enrollees who are experiencing an emergency medical condition. A carrier may not require prior authorization for these services if a prudent layperson acting reasonably would have believed an emergency medical condition existed.¹⁶
- If an enrollee receives covered ground ambulance services, the enrollee satisfies their obligation to pay for the ground ambulance services if they pay the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract.¹⁶
- In November 2021, DOH released a Policy Statement entitled, "EMS Transport to Appropriate Alternative Medical Facilities" (EMS 21-02).¹⁷ The policy states, "EMS may transport individuals to alternative medical facilities when the patient is experiencing *nonemergent*, or *emergent but primary care treatable* conditions."¹⁷ The guidance specifies patients may be transported to specifically listed alternate locations under specified conditions.¹⁷
- In May 2023, the Governor signed Second Substitute Senate Bill (2SSB) 5120 ([Chapter 433, Laws of 2023](#)) into law, which authorized 23-hour Crisis Relief Centers (CRCs) ([RCW 71.24.916](#)) in Washington State and directed DOH to establish rules including standards for determining medical stability of patients before EMS transport to these facilities.¹⁸
 - A 23-hour CRC is a community-based behavioral health facility that offers access to mental health and substance use disorder care for no more than 23 hours and 59 minutes at a time per patient.¹⁸ A CRC must be open 24 hours a day, 7 days a week, and accept behavioral health crisis walk-ins, people transported by first responders, and people referred through the 988 system, regardless of behavioral health acuity, and without requiring medical clearance.¹⁸
 - In April 2024, Engrossed Second Substitute Senate Bill (E2SSB) 5853 ([Chapter 367, Laws of 2024](#)) was passed, authorizing CRCs to serve children in addition to adults, but prohibiting service of adults and children in the same treatment area.¹⁸

Other jurisdictions

- The Arizona Health Care Cost Containment System's (AHCCCS) Emergency Triage, Treat, and Transport Program allows registered Emergency Transportation Providers in possession of a Certificate of Necessity (CON) from the Arizona Department of Health Services, or Tribal providers who have signed the AHCCCS attestation of CON equivalency, to transport a patient to an alternative destination partner or provide treatment on scene as specified in its policy.¹⁹
- In 2024, New York State passed legislation (S8486C) expanding reimbursement for on-scene treatment, transport to approved healthcare facilities like urgent care and mental

health clinics, and telemedicine consultations.²⁰ The change became effective October 1, 2024.²⁰

Summary of HB 1864

- Updates RCW 18.73.280 to allow an ambulance service to transport patients to a facility other than an emergency department (ED), such as an urgent care clinic, a mental health facility, or a substance use disorder program, as authorized in regional emergency medical services (EMS) and trauma care (TC) plans under RCW 70.168.100.
- Requires a health carrier offering a health plan issued or renewed on or after January 1, 2026, to provide coverage for ground ambulance transport to a facility other than an ED, such as an urgent care clinic.
 - [Chapter 48.43 RCW](#) impacts all fully-insured health plans in Washington State, including individual and small group/small employer plans offered on the Exchange and Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) government-sponsored plans (personal communication, HCA, February 2025). The provisions in the bill would not apply to self-insured plans (large employer plans), which must comply with federal laws and are not subject to state laws (personal communication, HCA, February 2025).
 - Allows coverage to be subject to applicable in-network copayments, coinsurance, and deductibles, as provided in [Chapter 48.49 RCW](#) (Balance Billing Protection Act).
- Directs HCA to update reimbursement methodology for ambulance services when transporting a person enrolled in Apple Health (Medicaid) to include transport to a facility other than an ED.
- Updates the definition of “patient care procedures” in Chapter 70.168 RCW (Statewide Trauma Care System) to include a substance use disorder program or other nonemergency department facility, such as an urgent care clinic.
 - Requires regional EMS-TC councils to update procedures to allow for the transport of patients to facilities other than EDs, such as urgent care clinics.
- Reenacts and amends RCW 18.71.210 to include transport of patients to facilities other than EDs, such as urgent care clinics and substance use disorder programs.

Health impact of HB 1864

Evidence indicates that HB 1864 would likely result in DOH conducting rulemaking; some regional EMS-TC councils adopting ambulance transport procedures for facilities other than EDs into regional EMS-TC Patient Care Procedures; and some medical program directors and local EMS-TC councils developing a county operating procedure, writing a patient care protocol, and identifying facilities to accept referrals; which may result in some patients being transferred to facilities other than EDs. It is not well researched how provisions may impact health outcomes.

Pathway to health impacts

The potential pathway leading from provisions of HB 1864 to health and equity are depicted in Figure 1. We made the informed assumptions that allowing an ambulance service to transport

patients to a facility other than an ED, as authorized in RCW 70.168.100, would likely result in DOH conducting rulemaking to enable ambulance services to transport patients to facilities other than EDs, some regional EMS-TC councils adopting ambulance transport procedures for these facilities into the regional EMS-TC Patient Care Procedures (PCP), and some medical program directors (MPDs) and local EMS-TC councils developing a county operating procedure (COP), writing a patient care protocol (protocol), and identifying facilities to accept referrals. These informed assumptions are based on previous DOH guidance, a review of regional EMS-TC councils' FY 2024-2025 Strategic Plans and PCPs, implementation of previous transport procedures, and information from key informants and the published literature. There is a fair amount of evidence that some MPDs and local EMS-TC councils developing a COP, writing a protocol, and identifying facilities other than EDs that accept referrals may result in transport of some patients to facilities other than EDs.²¹⁻²⁵ It is not well researched how transporting some patients to facilities other than EDs may impact health outcomes.^{22,23,26}

Scope

Due to time limitations, we only researched the most linear connections between provisions of the bill and health and equity and did not explore the evidence for all possible pathways. For example, we did not evaluate potential impacts related to:

- Non-emergent health concerns. Research has evaluated potential causes of non-emergent 911 calls, ambulance transport, and ED treatment. Key informants in Washington State stated that many calls to 911 are due to non-emergent reasons (e.g., minor scratch from a pet, stepped on a nail and requires a Tetanus shot, persistent cough, needs antibiotics) (personal communication, Washington Council of Fire Fighters [WSCFF], February 2025). However, researchers have stated that it is difficult to determine how many non-emergent patients may be transported by ambulance or treated in EDs since various definitions and criteria are used to classify patients as non-emergent/non-urgent.²⁶ Previous research has suggested anywhere from 11% to 61% of ambulance transports may not require care in the ED,²⁶ and anywhere from 4.8% to 90% of people who receive care in the ED may be treated for conditions that could be appropriately treated in less emergent settings.^{21,26} Researchers have suggested that use of EDs for non-emergent care may be due to patient preference, convenience, lack of a regular healthcare provider, limited access to healthcare, and insurance status.²¹ EDs are also “a safety net for patients, especially those without a primary care physician or patients with chronic medical problems who require treatments best addressed in the ED.”²⁶ Treatment of non-emergent health concerns in the ED may take longer and may be more expensive than treatment provided in other medical settings.²¹ In addition, patients treated for nonurgent conditions in the ED may not receive preventive healthcare or services that may be available in other healthcare settings.²¹ This Health Impact Review did not examine the structural and social determinants of health that may result in non-emergent 911 calls, ambulance transport, and ED treatment.
- ED wait times and extended ambulance patient offload times (APOT or “wall times”) at a hospital. Previous research has found that “the use of the ED for nonurgent health needs can contribute to ED overcrowding, a situation that may jeopardize patients’ health by

diverting or delaying health resources for the most acute patients.”²¹ Key informants in Washington State stated that ambulances must wait at an ED until care of the patient is transferred from EMS personnel to ED staff (personal communications, February 2025). Long wait times in the ED (e.g., due to high patient volumes, disease outbreaks) may remove an ambulance from the community and limit EMS staff’s ability to respond to emergency calls (personal communications, February 2025). Urban areas with higher population and patient volumes may especially experience long wait times (personal communication, DOH, February 2025). This Health Impact Review did not evaluate the impact of HB 1864 on ED wait times or EMS wall time.

- Transportation to facilities not named in HB 1864. HB 1864 states that an ambulance service may transport patients to a facility other than an ED, such as an urgent care clinic, a mental health facility, or a substance use disorder program, as authorized by regional councils. Key informants stated that the language “such as” includes facilities as examples of potential alternative destinations but does not require transport to these locations or limit transport to these locations (personal communications, February 2025). Key informants suggested that, based on the bill language, facilities like community health centers, provider offices that accept walk-in patients, or other locations could be allowed. This Health Impact Review did not evaluate potential impacts for all possible types of alternative facilities; rather, this review focused on facility types explicitly named in HB 1864.
- Other EMS programs and interventions. Many key informants mentioned additional EMS programs and interventions that may support or impact implementation of alternative destination transportation. For example, some fire departments and districts in Washington State provide Mobile Integrated Health, which works with social workers and nurses to provide additional care to patients who call 911 (personal communication, WSCFF, February 2025). Some districts arrange taxi or rideshare transport to alternative destinations (doctor’s office, urgent care clinics, etc.) if a patient does not need treatment in an ED (personal communications, February 2025). Other districts offer a nurse navigation line that patients or EMS personnel can call to help triage healthcare concerns and direct patients to appropriate care (i.e., telemedicine visits, treat at home, rideshare to urgent care clinic, ambulance transport to ED if needed) (personal communications, February 2025). This Health Impact Review did not evaluate how other EMS programs and interventions in Washington State may impact implementation of alternative destination transportation.
- Qualified immunity. [RCW 18.71.210](#) addresses liability for advanced EMTs and paramedics. Generally, under this law, advanced EMTs, paramedics, or other medical personnel are not subject to civil liability when they act in good faith while providing EMS. HB 1864 would add transport to facilities other than EDs, in accordance with applicable alternative facility procedures adopted under RCW 70.168.100, to those activities. This Health Impact Review did not evaluate the relationship between qualified immunity and transport of patients to facilities other than EDs.

Magnitude of impact

HB 1864 has the potential to impact all ambulance service providers in Washington State as well as people who access EMS in Washington State. HB 1864 would impact all ambulance service providers, regardless of the organization, including private ambulance service providers, fire departments and districts, law enforcement agencies, ski patrols, border patrol, and the U.S. Forest Service (personal communication, DOH, February 2025).

EMS agencies offer 3 types of services, with different services provided at each level of care, including Basic Life Support (BLS), Intermediate Life Support (ILS), and Advanced Life Support (ALS).⁶ Ambulance services may be publicly or privately owned and operated.⁶ Public providers include fire departments and districts, public hospital districts, and EMS districts and are funded through local government taxes, levies, and third party payers.⁶ Privately owned and operated ambulance service providers operate through various models but typically respond to 911 calls in partnership with or at the request of public EMS services.⁶ Private ambulance service providers also provide interfacility and specialty care transports.⁶ Private ambulance services are funded through Medicare, Medicaid, and private health insurance.⁶ Tribes may also own and operate ambulance services.⁶

As of December 31, 2024, there were 461 total licensed EMS services in Washington State, including 303 ambulance services (i.e., 291 trauma verified ground ambulance services and 12 licensed ground ambulance services), 155 aid services, and 3 air ambulance services (unpublished data, DOH, February 2025). There were also 1,662 licensed EMS vehicles, including 1,589 Licensed Ground Ambulances, 77 Licensed Rotor Wing Ambulances, and 23 Licensed Fixed Wing Ambulances operating in Washington State (unpublished data, DOH, February 2025).

The State is divided into 8 EMS-TC Regions. As of December 31, 2024:

- Central Region (King County) had 1 licensed ambulance service and 27 trauma verified ambulance services;
- East Region (Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, and Whitman Counties) had 6 licensed ambulance services and 33 trauma verified ambulance services;
- North Region (Island, San Juan, Skagit, Snohomish, and Whatcom Counties) had 1 licensed ambulance service and 53 trauma verified ambulance services;
- North Central Region (Chelan, Douglas, Grant, and Okanogan Counties) had 0 licensed ambulance services and 26 trauma verified ambulance services;
- Northwest Region (Clallam, Jefferson, Kitsap, and Mason Counties) had 0 licensed ambulance services and 28 trauma verified ambulance services;
- South Central Region (Benton, Columbia, Franklin, Kittitas, Walla Walla, and Yakima Counties) had 0 licensed ambulance services and 28 trauma verified ambulance services;
- South West Region South Central Region (Clark, Cowlitz, Klickitat, Pacific, Skamania, and Wahkiakum Counties) had 2 licensed ambulance services and 26 trauma verified ambulance services; and

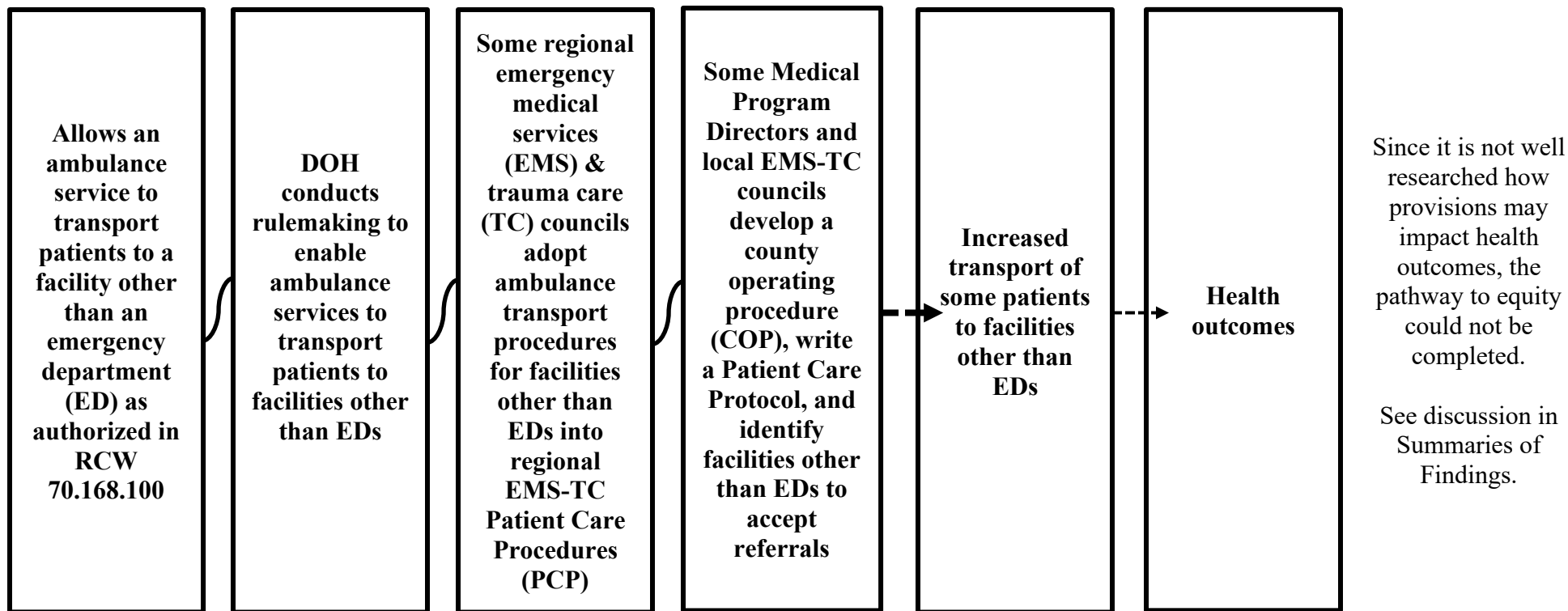
- West Region (Grays Harbor, Lewis, Pacific, Pierce, and Thurston Counties) had 3 licensed ambulance services and 69 trauma verified ambulance services (unpublished data, DOH, February 2025).

There were 18,611 EMS personnel in Washington State in 2024 (unpublished data, DOH, February 2025). EMS services are provided by personnel with 4 levels of certification: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced EMT, and Paramedic.⁶ About 79% of EMS personnel in Washington State are EMTs (unpublished data, DOH, February 2025).

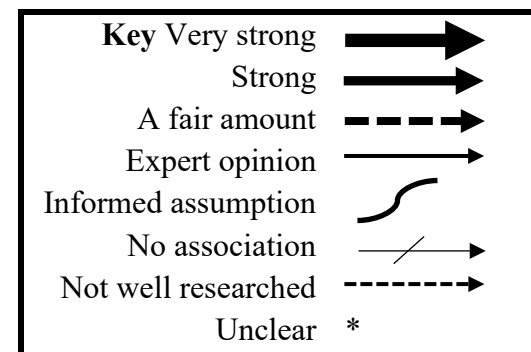
In Washington State in 2022, EMS responded to over 818,000 emergency calls.⁶ Of all emergency calls, 684,000 calls (83.6%) resulted in EMS transport.⁶

Overall, HB 1864 has the potential to affect ambulance service providers and people who access EMS in Washington State.

Logic Model



**Figure 1:
Transporting patients by ambulance to
facilities other than emergency departments
HB 1864**



Summaries of Findings

Would allowing an ambulance service to transport patients to a facility other than an emergency department, as authorized in RCW 70.168.100, result in the Washington State Department of Health conducting rulemaking to enable ambulance services to transport patients to facilities other than emergency departments?

We have made the informed assumption that allowing an ambulance service to transport patients to a facility other than an emergency department (ED), as authorized in [RCW 70.168.100](#), would likely result in the Washington State Department of Health (DOH) conducting rulemaking to enable ambulance services to transport patients to facilities other than EDs. This informed assumption is based on the implementation of previous changes to state law, other DOH guidance, and information from key informants.

If passed, HB 1864 would allow ambulance services to transport patients to facilities other than EDs, as authorized in regional EMS-TC councils' Patient Care Procedures (PCPs). The bill would also update the definition of PCPs to reflect this language.

Under current Washington State laws and regulations, ambulance services may transport patients to: “an appropriate medical facility” ([RCW 18.73.030](#)[10]) or “recognized medical treatment facility” ([WAC 246-976-010](#)[40]) and nonmedical facilities, such as a mental health facility or substance use disorder program ([RCW 18.73.280](#)), as authorized in regional EMS-TC plans.

In 2015, the Washington State Legislature passed Substitute House Bill (SHB) 1721 ([Chapter 157, Laws of 2015](#)), which gave ambulance services specific authority to transport patients voluntarily to nonmedical facilities, such as mental health facilities and chemical dependency treatment programs.²⁷ The law ([RCW 70.168.170](#)) also required DOH and Department of Social and Health Services (DSHS) to convene a workgroup to establish alternative facility guidelines by July 1, 2016, for ambulance services to transport patients in need of mental health or chemical dependency services.²⁷ DOH issued an “EMS Guideline for Transport to Mental Health and Chemical Dependency Services” to guide implementation of SHB 1721 (SHB 1721 Guideline) (personal communications, February 2025). Following the passage of legislation authorizing 23-hour Crisis Relief Centers (CRCs) ([Chapter 433, Laws of 2023](#) and [Chapter 367, Laws of 2024](#)), DOH's Office of Emergency Management Care Systems released its current “EMS Guideline for Transport to Behavioral Health Facilities” (Behavioral Health Transport Guideline) in June 2024.²⁸ For the purposes of the updated Behavioral Health Transport Guideline, the term “behavioral health facilities” is inclusive of mental health and substance use disorder (SUD) facilities and services.²⁸

While not included in either the SHB 1721 Guideline or Behavioral Health Transport Guideline, DOH addresses transport to additional alternative facilities in an agency Policy Statement. In November 2021, DOH released its “EMS Transport to Appropriate Alternative Medical Facilities” Policy Statement (EMS 21-02) to help reduce the burden on EDs for non-emergent care during the COVID-19 pandemic (personal communication, DOH, February 2025). EMS 21-02 states, “EMS may transport individuals to alternative medical facilities when the patient is experiencing *nonemergent*, or *emergent but primary care treatable* conditions.”¹⁷ When all conditions identified in ESM 21-02 are met, patients may be transported to: 1) a mental health

facility or substance use disorder treatment program; 2) an Alternative Care Facilities (ACF) established by the state or federal government under a local or statewide emergency declaration; 3) isolation and quarantine sites established by a local health or state jurisdiction in response to communicable disease outbreaks; 4) medical facilities such as healthcare clinics established under a federally-recognized Tribe; and 5) urgent care facilities established by a licensed hospital system.¹⁷ For example, under EMS 21-02 to transport a patient to an urgent care facility established by a licensed hospital system: “The Medical Program Director [MPD] must perform ongoing quality assurance activities to monitor transports to these facilities. A [DOH] approved EMS [MPD] Patient Care Protocol [Protocol] that identifies inclusion and exclusion criteria for patients that may be transported to the site is in place.”¹⁷ However, the guidance provided in the EMS 21-02 has not been codified and DOH does not have authority to enforce Policy Statements (personal communication, DOH, February 2025).

While DOH did not conduct rulemaking following passage of SHB 1721, DOH does have the necessary authority (personal communication, DOH, February 2025). DOH’s Fiscal Note for HB 1864 states that DOH would develop and adopt rules to enable ambulance services to transport patients to facilities other than EDs and would do so if the bill were to pass.²⁹ The Fiscal Note states that DOH anticipates using a team of subject matter experts to implement HB 1864 and would identify and engage underreached communities in the rulemaking process.²⁹ Additionally, the EMS-TC Steering Committee is responsible for reviewing proposed DOH rules for EMS and trauma care and recommending modifications of the rules.¹³ The 30-member Steering Committee includes members appointed by the Secretary of Health who serve as representatives from surgeons and physicians, hospitals, prehospital providers, firefighters, local health departments, consumers and other affected groups.¹³ Lastly, key informants representing regional and local councils stated that DOH typically engages all levels of the EMS system in the rulemaking process (personal communications, February 2025).

Key informants identified multiple challenges to expanding ambulance transport to facilities other than EDs. Most key informants noted that federal law (Emergency Medical Treatment & Labor Act [EMTALA] of 1986) guarantees access to emergency services regardless of a patient’s ability to pay in hospital settings (personal communications, February 2025). The law imposes specific obligations on Medicare- and Medicaid-participating hospitals that offer emergency services,⁷ which includes most U.S. hospitals.¹ The law gives everyone in the U.S., regardless of insurance status, ability to pay, race, color, national origin, sex, religion, disability, age, or citizenship status, the following protections: 1) an appropriate medical screening exam to check for an emergency medical condition, and if the patient has one; 2) treatment until the emergency medical condition is stabilized, meaning the condition is unlikely to get materially worse, or; 3) if necessary, an appropriate transfer to another hospital with the staff and facilities available to stabilize the emergency medical condition.¹ Before transferring the patient, the hospital must explain the benefits and risks to the patient.¹ However, EMTALA’s patient protections do not apply to ground ambulance services⁶ or to urgent care clinics unless they are under the license of a hospital subject to the law (personal communications, February 2025). Key informants stated that transporting a patient to a facility that is not covered by EMTALA may result in delayed or denied care for patients who cannot afford to pay for services, required co-payments, etc. (personal communications, February 2025). For discussion of potential impacts on costs for patients, see “Additional Considerations” on page 30.

Moreover, urgent care facilities are not licensed or regulated by DOH (personal communications, February 2025). Washington State does not have a facility license requirement for urgent care clinics or freestanding ED facilities; therefore, regulatory oversight is limited to regulating providers under their professional credential versus regulating the facility (personal communication, DOH, February 2025). The exception is urgent care clinics or free standing ED facilities that are licensed as part of a hospital (personal communication, DOH, February 2025). Only in these instances, through facility regulation, can DOH ensure standards of care, investigate or respond to incidents, or take action on facilities if a patient was not provided adequate or appropriate care (personal communication, DOH, February 2025). Previous research has emphasized that alternative destination transportation (i.e., EMS transport to facilities other than EDs) must optimize safety and assure a standard of care at alternative facilities.²¹

Additionally, state law ([RCW 18.71.215](#)) establishes that DOH:

shall defend and hold harmless approved [MPDs], delegates, or agents, including but not limited to hospitals and hospital personnel in their capacity of training [EMS] personnel for certification or recertification pursuant to [Chapter 18.71 RCW] at the request of such [MPDs], for any act or omission committed or omitted in good faith in the performance of their duties.

Therefore, as DOH and the Secretary of Health are liable for the acts and omissions of MPDs and the personnel operating under their supervision, the agency would need to identify ways to reduce its risks to develop appropriate alternate transport options (personal communication, DOH, February 2025). For example, if an alternate facility that is not subject to the patient protections required by EMTALA is approved to receive patients via ambulance transport but refuses to accept a patient, such refusal could put DOH at risk if the patient does not receive timely, appropriate emergency care.

Some key informants shared concerns about EMS personnel's ability to appropriately triage patients for transport to alternative destinations rather than a hospital (personal communications, February 2025). Similarly, researchers have found mixed results related to EMS triage,^{23,30} and research has suggested there may be challenges to EMS personnel triaging patients to alternative destinations. DOH staff stated that the agency has not been made aware of any instances of quality assurance problems with EMS transporting patients to mental health facilities, chemical dependency programs, isolation and quarantine facilities, or federally-recognized Tribal clinics (personal communication, DOH, February 2025). However, staff stated there are a limited number of facilities, transports to these facilities have a very narrow inclusion criteria, and therefore transports directly to these facilities without an evaluation from an emergency physician do not occur often (personal communication, DOH, February 2025).

Lastly, it is unknown which facility types would be included in adopted DOH rules. For example, key informants noted the phrase "such as" in HB 1864 could allow for broad interpretation of what facility types may be allowable to accept ambulance transport (personal communications, February 2025). Key informants identified multiple types of facilities (e.g., 23-hour behavioral health CRCs, urgent care clinics, community health centers, skilled nursing facilities) that may be best positioned to care for some patients calling EMS services (personal communications, February 2025). Some key informants stated the facility types explicitly listed in HB 1684 represent examples but not an exhaustive list of potential additional facility types that could accept patients from ambulance transport (personal communications, February 2025). However, HB 1864 would not require the inclusion of any specific facility type (listed or

unlisted) as an allowable alternative destination for ambulance transport; such determinations would be made during DOH rulemaking.

Since DOH staff stated that rulemaking would be inclusive of the facility types addressed in the Behavioral Health Transport Guideline as well as the 2021 Policy Statement (personal communication, DOH, February 2025), we have made the informed assumption that HB 1864 would likely result in DOH conducting rulemaking to enable ambulance services to transport patients to facilities other than EDs.

Would DOH conducting rulemaking to enable ambulance services to transport patients to facilities other than EDs result in some regional EMS-TC councils adopting ambulance transport procedures for facilities other than EDs into the regional EMS-TC Patient Care Procedures?

We have made the informed assumption that DOH conducting rulemaking to enable ambulance services to transport patients to facilities other than EDs would likely result in some regional EMS-TC councils adopting ambulance transport procedures for facilities other than EDs into the regional EMS-TC PCPs. This informed assumption is based on previous DOH guidance, a review of regional EMS-TC councils' FY 2024-2025 Strategic Plans and PCPs, and information from key informants.

Once DOH adopts rules, it is the responsibility of the 8 regional EMS-TC councils to develop regional EMS-TC plans (RCW 70.168.100) to operationalize DOH guidance in a way that works for each unique region (personal communications, February 2025). Each regional plan includes in-depth implementation guidelines and goals and addresses issues relating to demographics, education and training, communication, quality assurance, prevention and public education, prehospital services, acute and rehabilitation facilities, and PCPs.¹⁴ The regions work to ensure that EMS is a cohesive system, that all parties are communicating, and that all parts of the system follow the same rules (local fire department, hospitals, dispatch centers, law enforcement, EMS personnel, private ambulances, etc.) (personal communications, February 2025). PCPs are the written operating guidelines adopted by the regional EMS-TC councils with input from local EMS-TC councils, emergency communication centers, and county EMS MPDs.² PCPs define how each EMS-TC system operates and must meet minimum statewide standards. Specifically, PCPs shall:

identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility, mental health facility, or chemical dependency program to first receive the patient, and the name and location of [facilities] to receive the patient should an interfacility transfer be necessary.³¹

All regional plans have PCPs to address basic system functions, and the EMS-TC Steering Committee and DOH review PCPs included as part of each approved regional plan.²

Regional EMS-TC strategic plans are developed and completed on a 2-year cycle, and each PCP is reviewed once each cycle (personal communication, Regional EMS-TC Council staff, February 2025). Regions may choose to update all PCPs at once or to review a few PCPs at a time over the 2-year period (personal communication, Regional EMS-TC Council staff, February 2025). When legislation passes, there is usually a timeframe by which regional EMS-TC councils need to have an adopted PCP in place (personal communication, regional EMS-TC council staff, February 2025). It can take 2 to 6 months to draft a PCP with involvement from

partners and input from local EMS councils and EMS MPDs (personal communication, regional EMS-TC council staff, February 2025). Regions then work with DOH to have language reviewed and approved before bringing the PCP to the regional EMS-TC council for approval during an open public meeting (personal communications, February 2025).

In 2015, SHB 1721 (RCW 70.168.100) directed regional plans to “identify procedures to allow for the appropriate transport of patients to mental health facilities or chemical dependency programs, as informed by the alternative facility guidelines” adopted by DOH.³² Following passage of the new law, DOH developed and released its SHB 1721 Guideline for transport to newly allowable facilities and services (personal communications, February 2025).

As of February 12, 2025, 6 of the 8 regions had adopted PCPs to operationalize RCW 70.168.170 (SBH 1721) and allow ambulance services to transport patients to mental health facilities or chemical dependency programs, if approved by the county’s EMS MPD.³³⁻⁴⁰ Plans vary in the level of detail and direction included. For example, of the 6 regions with PCPs about transportation to these alternate destinations, 4 regions include language that participating facilities work with the county EMS MPD and EMS agencies to establish criteria that all participating facilities and EMS agencies will follow for accepting patients.^{34-36,40} One region details information that local EMS-TC councils and EMS MPDs must include in the county operating procedure (COP) (e.g., dispatch criteria, a list of approved facilities participating, and the standardized criteria for accepting patients).³⁵ At least 1 region set a timeline by which local EMS-TC councils had to develop a COP consistent with the DOH SHB 1721 Guideline for implementation of transport to mental health facilities or chemical dependency programs.⁴⁰ Finally, as part of the rationale for establishing PCPs, 1 region noted that an MPD who incorporated SHB 1721 guidelines into the updated mental health transport protocol had “reported some progress in deflecting admission of behavioral health patients in the ED.”⁴⁰

Of the 2 regions that did not have a PCP operationalizing transport of patients to mental health facilities or chemical dependency programs, 1 included a region-specific PCP in which “selected patients may be transported to a clinic, urgent care clinic, free standing [ED], or hospital-based ED via [basic life support] BLS transport if the patient meets [specific] criteria”.³³ The region also included a Taxi Voucher Transportation Policy to transport selected patients to a clinic, urgent care clinic, free standing ED, or hospital-based ED via taxi in specified conditions.³³ Key informants within the region confirmed transports to alternate destinations are occurring (e.g., to identified urgent care clinics associated with a hospital, primary care clinic partners); however, they were unsure how often these procedure are used (personal communications, February 2025).

In 2024, following the creation of Washington State’s 23-hour CRCs, DOH updated the guidance to reflect allowable transport to behavioral health facilities (i.e., mental health and substance use disorder facilities and services).²⁸ The Behavioral Health Transport Guideline outlines requirements the regional EMS-TC councils shall include in PCPs (defined in [WAC 246-976-010](#)) to provide guidance to EMS MPDs and EMS services to operationalize transport of patients to a behavioral health facility.²⁸ Specifically, the Behavioral Health Transport Guideline provides direction to support: 1) regional EMS-TC councils in developing regional PCPs; 2) local EMS-TC councils in developing COPs; and 3) EMS physician MPD in developing their prehospital Patient Care Protocols (protocols) for EMS transport to behavioral

health facilities.²⁸ Key informants from various regional EMS-TC councils shared that their region was in the process of updating current PCPs allowing EMS to transport patients from emergency scenes directly to mental health facilities and chemical dependency programs to reflect the language used in DOH's updated Behavioral Health Transport Guideline (personal communications, February 2025).

Therefore, since DOH has previously issued guidance to provide direction to regional EMS-TC councils for developing PCPs; and 7 regional EMT-TC councils used guidance to adopt PCPs addressing ambulance transport to alternative locations (6 to mental health facilities and chemical dependency programs; 1 to clinics, urgent care clinics, free standing EDs, or hospital-based EDs), we have made the informed assumption that DOH rulemaking would likely result in some regional EMS-TC councils adopting ambulance transport procedures for facilities other than EDs into the regional EMS-TC PCPs.

Would some regional EMS-TC councils adopting ambulance transport procedures for facilities other than EDs into regional EMS-TC PCPs result in some MPDs and local EMS-TC councils developing a COP, writing a patient care protocol, and identifying facilities other than EDs to accept referrals?

We have made the informed assumption that some regional EMS-TC councils adopting ambulance transport procedures for facilities other than EDs into regional EMS-TC PCPs would likely result in some EMS physician MPDs and local EMS-TC councils developing a COP, writing a protocol, and identifying facilities other than EDs to accept referrals. This informed assumption is based on implementation of previous transport procedures, information from key informants, and information from the published literature.

To support implementation of SHB 1721 and 23-hour CRCs at the local level, DOH's Behavioral Health Transport Guideline also includes guidance for local EMS-TC councils in developing COPs and MPDs in developing their prehospital protocol.²⁸ Specifically, it directs local EMS-TC councils to collaborate with the MPD to develop a COP that includes standards for transport to a behavioral health facility that are consistent with the state standards and the local regional EMS-TC council's PCP.²⁸ For example, among other standards, the COP must include a list of approved facilities participating in the program and destination determination criteria including considerations for transports that may take the EMS service out of its county of origin.²⁸ All 6 regional EMS-TC PCPs that include an ambulance transport procedure for mental health and chemical dependency destinations include language that participating agencies and facilities will adhere to implementation guidance in DOH's SHB 1721 Guideline.^{34-36,38-40}

Additionally, the Behavioral Health Transport Guideline requires MPDs to develop a protocol (as defined in WAC 246-976-010) consistent with the standards and screening criteria in the Guideline as well as with state standards, regional EMS-TC council PCPs, and COPs.²⁸ The protocol should assist EMS providers in: 1) determining when a medical emergency requires immediate care; 2) assessing the risk the patient presents (i.e., to self, the public, and EMS personnel); and 3) determining the severity of a behavioral health emergency.²⁸ MPDs are also responsible for developing and implementing DOH-approved education for EMS personnel who will respond and transport patients to behavioral health facilities.²⁸ As MPDs establish parameters for EMS providers, they may collaborate with participating facilities to determine:

receiving facilities within the county; acceptable age range for transport; acceptable vital sign ranges; triage criteria for people with functional and access needs; procedures for uncooperative or combative patients (if applicable); self-care criteria; and criteria for indwelling lines, tubes, and catheters that patients cannot manage themselves.²⁸

It is not possible to predict which MPDs will authorize transport to facilities other than EDs. Regional PCPs state that EMS transport of patients from the field to alternate allowable facilities may only occur if approved by the county MPD. EMS-TC Regions consist of 1 to 9 counties, each of which has an MPD responsible for developing and adopting written prehospital patient care protocols to direct EMS/TC certified personnel in patient care, among other duties.⁴¹ Under state law ([RCW 18.71.205](#)), actions of emergency medical technicians (EMTs) and paramedics are limited to those taken under the express written or oral order of MPDs. As EMTs and paramedics operate under the license and delegation of the county's MPD, key informants shared that each MPD may have a different comfort level with EMS transporting patients directly from the field to facilities other than EDs (personal communications, February 2025). Moreover, each MPD operates within a local context, which has unique patient needs and locally available resources (facilities, personnel, etc.) (personal communications, February 2025). Although most regional EMS-TC councils have adopted a PCP allowing EMS transport to mental health facilities or chemical dependency programs, some regions have not seen any MPDs authorize and develop protocols for transport to these alternate facilities (personal communications, February 2025). A patchwork of authorization exists in other regions, where some MPDs have authorized transport to facilities allowed under current DOH guidance and others have not (personal communications, February 2025). Some key informants stated they would expect implementation of HB 1864 to play out similarly (personal communications, February 2025).

If local EMS-TC councils and the MPD were to use DOH guidance to develop COPs and to write protocols for EMS transport to facilities other than EDs, it is unknown how many patients may qualify for such transport or which facilities may be identified as appropriate or recognized. For example, DOH's Behavioral Health Transport Guideline states that EMS should only transport patients to behavioral health facilities when: the EMS agency was dispatched via 911; the receiving facility is licensed; the receiving facility is approved by the MPD and identified in the MPD protocols and COP; the receiving facility has bed availability; the EMS provider uses their judgement based on MPD protocols; and the patient meets specified inclusion (e.g., the patient must have a behavioral health chief complaint) and exclusion criteria (e.g., the patient must not be suspected of having another medical issue that requires medical evaluation in an ED) outlined in the DOH Behavioral Health Transport Guideline.²⁸ Key informants shared that the current inclusion and exclusion criteria for EMS transport to behavioral health facilities is narrow and significantly limits the number of patients eligible for transportation to an alternative facility (personal communications, February 2025).

It is also not possible to predict which facilities other than EDs may be identified by and included in COPs and protocols as appropriate or recognized facilities. Many key informants noted the importance of tailoring EMS protocols to local contexts (personal communications, February 2025). Research has suggested that there may be limited alternative facilities in some counties or regions and "geographical considerations play an important role as densely populated urban areas may be able to facilitate [alternative destination transportation] of patients better than

rural areas with fewer resources.”²³ For these reasons, protocols and processes “must be specific to individual healthcare systems.”²³ It is not possible to predict which counties may have alternative facilities approved for patient transport.

It is also not possible to predict which allowable facilities may be willing to accept ambulance transports.³⁰ Ambulance service providers must establish contracts with alternative providers. Many key informants stated that, even with approved PCPs allowing transport to alternative destinations, alternate facilities may not be engaged or willing to accept patients from ambulance transport (personal communications, February 2025). Among many considerations, key informants shared that some allowable facilities may not contract with ambulance service providers because the facility may not be physically equipped to handle emergency transport. For example, many urgent care facilities do not have ambulance bays and do not have waiting rooms set up to accommodate patients transported by ambulance (e.g., space for a stretcher) (personal communications, February 2025). Researchers have also stated that ambulance transportation to urgent care clinics “has been restricted by the complexity and rigidity of clinic schedules, non-standardized capabilities of [urgent care clinics], and regulatory restrictions, including restricted insurer payments when patients are not transported to EDs.”⁴²

Research has shown that allowable facilities face challenges in implementing alternative destination transportation and may not participate in the program. From January 1, 2021, through December 31, 2023, the U.S. Centers for Medicare & Medicaid Services (CMS) conducted a voluntary Emergency Triage, Treat, and Transport (ET3) Model pilot program that allowed ground ambulance providers to provide treatment in place or alternative destination transportation to eligible Medicare patients who agreed to participate in an ET3 option.²² As part of the alternative destination transportation option, patient transport was allowed to an urgent care clinic, a federally-qualified health center, an outpatient clinic, or another approved location.²² CMS found low participation in alternative destination transportation.²²

Among ambulance organizations that implemented ET3, CMS found that organization size, type of organization (e.g., fire departments, private ambulance services), or geographic location (i.e., urban or rural) did not predict successful implementation of ET3.²² Rather, successful implementation was due to a commitment to implement ET3.²² Ambulance organizations noted that successfully implemented ET3 “required significant organizational resources, including relationship building with providers and payers; staff bandwidth; infrastructure and equipment; and training and retraining of EMS ambulance personnel.”²² The primary challenge to implementing alternative destination transportation by EMS was difficulty obtaining agreements with alternative destination facilities and the limited number of alternative facilities with capacity to accept ambulance transport patients.²² Potential partners were concerned about capacity (e.g., due to the COVID-19 pandemic), legality, and operational procedures.²² More specifically, potential alternative destination partners expressed uncertainty about the legitimacy of the ET3 options and “were concerned about operational risks such as receiving acutely ill patients they were not equipped to manage, not knowing when patients would arrive, or the potential that patients would need transportation back to their residence.”²²

While it is not possible to predict which facilities other than EDs may be allowed, which allowable facilities may accept referrals, or which locations may have allowable facilities, we

have made the informed assumption that HB 1864 may result in some MPDs and local EMS-TC councils developing a COP, writing a protocol, and identifying facilities other than EDs to accept referrals.

Would some MPDs and local EMS-TC councils developing a COP, writing a protocol, and identifying facilities other than EDs to accept referrals result in transport of some patients to facilities other than EDs?

There is a fair amount of evidence that some MPDs and local EMS-TC councils developing a COP, writing a protocol, and identifying facilities other than EDs to accept referrals may result in transport of some patients to facilities other than EDs. Overall, research has found mixed results for how alternative destination transportation may impact ambulance service efficiency, including ambulance cycle times (i.e., time needed to prepare an ambulance for another response) or the rate of transporting patients to facilities other than EDs.²³ In general, research has shown low use of alternative destination transportation, with transport to alternative facilities accounting for very small percentages of overall ambulance transports (i.e., less than 1%).^{21,22,25} However, there is some research demonstrating that allowing EMS to transport patients to alternative destinations may result in some patients being transported to facilities other than EDs, which may reduce burden on EDs and increase care in clinics.^{21,22,43}

From December 1999 through January 2001, researchers conducted a pilot program with 2 fire agencies in King County, Washington, to determine whether EMS transport to alternate destinations (e.g., urgent care clinics, walk-in clinics, office-based healthcare provider practices accepting walk-in patients) could decrease ED use for patients with non-emergent health concerns.²¹ During the study period, 18% of calls (1,016 out of 5,724 calls) to the 2 fire agencies met eligibility criteria for alternative destination transportation.²¹ Of eligible calls, 0.80% (81 patients) were referred to and treated at an alternate destination.²¹ The study authors found that patient preference and limited clinic hours accounted for 80% of the reason eligible patients were not referred to or treated at an alternate destination.²¹ Other reasons included that the EMT decided ED care was more appropriate based on the situation or medical comorbidity; the clinic requested the patient go to the ED for medical reasons; and the clinic requested the patient go to the ED for logistical reasons (e.g., clinic was too busy).²¹ Overall, the study found that alternative destination transportation significantly decreased ED use by 15% and significantly increased clinic use by 80% during the study period, suggesting that alternative destination transportation may reduce burden on EDs.²¹

In Canada, a pilot program allowed paramedics to transport people who are intoxicated or experiencing mental health concerns to a facility other than an ED.⁴³ The study authors concluded that the alternative destination transportation pilot program had the potential to divert 1 in 6 patients experiencing intoxication or mental health concerns to a facility other than the ED.⁴³ Similarly, a study evaluating alternative destination transportation to a community mental health facility in North Carolina found that 40% of patients who were transported to the community mental health facility “were exclusively treated and stabilized” at the facility and discharged home.²⁴

During the COVID-19 pandemic, San Francisco Department of Public Health allowed EMS transport for patients with low-acuity health concerns to field clinics to reduce strain on EDs.²⁵

An evaluation of one field clinic found that only 0.3% of all ambulance transports (35 patients) were transported by EMS to the field clinic, with most transports occurring within the first 3 months of implementation.²⁵ The authors stated that the field clinic's hours of operation may have been a main reason for underuse as about half of EMS calls occurred outside of the field clinic's hours.²⁵ They noted that protocols at the field clinic meant that "[h]ours of operation could vary, making it difficult for EMS clinicians to know if the [clinic] was open to receiving patients."²⁵ This resulted in a "narrative of patient offload delays at the clinic compared to the [ED]", and "EMS clinicians were never in a situation where an existing ED was not available to accept their patients, perpetuating the use of routine, rather than novel processes."²⁵ However, "despite the small cohort size, this study demonstrates that an [...] alternative care site can act as a viable source for urgent and emergency care during a pandemic."²⁵

Key informants in Washington State also stated that delays or denials at an alternative destination may deter EMS personnel from transporting future patients to facilities other than EDs (personal communications, February 2025). Key informants stated that some ambulances may get turned away from an alternative facility (closed, capacity, patient is assessed as higher acuity, etc.) and must double-transport a patient to an ED (personal communications, February 2025). Key informants stated that there are challenges to tracking availability of alternate facilities based on hours of operation, services offered, and capacity to treat additional patients (personal communications, February 2025). Double-transports take ambulances out of service for longer and delay care, which may be harmful in urgent or emergency situations (personal communications, February 2025). Key informants shared that, if EMS personnel experience an alternative facility as not available then it is likely that transport option will no longer be used in the future even if it is technically available or allowable in policy (personal communications, February 2025).

CMS conducted a more recent pilot program. As part of the alternative destination transportation option of the ET3 Model pilot program, patient transport was allowed to urgent care clinics, federally-qualified health centers, outpatient clinics, or another approved location.²² CMS found low overall participation in treatment in place or alternative destination transportation, with ET3 options accounting for less than 1% (on average) of an ambulance organization's annual Medicare ambulance transports.²² The majority of ET3 interventions were treatment in place (92%); only 257 patients participated in alternative destination transportation.²² While use of ET3 options were overall low, CMS concluded that "[a]ssuming that an ED visit would have occurred absent [treatment in place or alternative destination transportation], these interventions may have been associated with between 70[%] and 85[%] fewer ED visits."²² However, CMS concluded that "[i]n theory, the ET3 Model appears to have some potential as a component of a broader strategy to reduce population reliance on EDs as a primary access point for health services. [...] However, the experience of the ET3 model showed that [...] delivery of ET3 interventions were severely limited by challenges to ET3 implementation and delivery."²²

CMS noted that patient refusal partially contributed to low use of alternative destination transportation.²² Patients "in an emergency medical situation tended to avoid departing from typical EMS care in an ED because of unfamiliarity with [treatment in place and alternative destination transportation] services."²² Other research has found that patients may be willing to participate in alternate destination transportation.^{23,30} In a survey with 621 patients and

caregivers presenting to an ED, researchers found that “63% of respondents agreed or strongly agreed that EMS should have the option to transport patients to alternative destinations (clinic, primary care office, urgent care) and nearly as many (61.8%) agreed or strongly agreed that they would prefer the alternate destination option to the current standard of transport to the [ED] if determined to be appropriate.”³⁰

Key informants stated there is also a disincentive for EMS providers to transport patients to locations other than the ED, which may limit the use of alternative destination transportation in Washington State. Non-emergent ambulance transport is currently reimbursed at a lower rate than emergency transport.⁶ In addition, if an alternative destination is located closer than an ED, the ambulance service may receive lower reimbursement overall, thereby disincentivizing transport to the alternative destination (personal communications, February 2025). For further discussion of reimbursement for ambulance service providers, see Additional Considerations on page 30.

Previous research has found that EMS training, organizational support, and processes have also presented barriers to successful implementation of alternative destination transportation.²³ EMS personnel have expressed concerns related to the absence of training or knowledge on triage processes; potential for liability or being held accountable for triage decisions; lack of a requirement or responsibility to refer patients to an alternative destination; lack of relationships with or knowledge about alternative destination partners; lack of information about patient outcomes after referrals; and patient expectations related to transport to EDs.²³ Low use of alternative transportation destinations in San Francisco were partly due to physician and paramedic unfamiliarity with field clinics; lack of routine consideration for alternative destination transportation; no requirement for transportation to an alternative destination; limited EMS experience with alternative destination transportation; and lack of buy-in from EMS agencies.²⁵

Lastly, while research has found that allowing alternative destination transportation may decrease transport to the ED, all of the studies found that a percentage of patients who were initially transported to an alternative facility were subsequently transported to an ED.^{21,22,24,43} For example, in North Carolina, about 9% of patients initially transported to the community mental health facility were transferred to an ED, with over half being transferred within 4 hours of arrival at the community mental health facility.²⁴ Over a 30-day follow-up period, 27% of patients had a return visit to the community mental health facility or an ED, which was higher than average ED follow-up during the study period (19.8%); 23% of return visits were to the community mental health facility and 77% of return visits were to an ED.²⁴ The CMS pilot study found that 7% of patients who participated in alternative destination transportation were subsequently transported to the ED on the same day and 24.5% were transferred to the ED within 5 days.²² None of the studies evaluated how subsequent transport to an ED impacted overall ED transport, use, or burden.

While it is not possible to predict how many patients may be transported to facilities other than EDs if HB 1864 were to pass, research suggests that some patients may be transferred to a facility other than an ED if alternative destination transportation is allowed. Therefore, there is a fair amount of evidence that allowing ambulance transport to alternative destinations may result in some patients being transported to facilities other than EDs.

Would transport of some patients to facilities other than EDs impact health outcomes?

It is not well researched how transporting some patients to facilities other than EDs may impact health outcomes. Both key informants and evidence from qualitative published research has suggested support for alternative destination transportation (personal communications, February 2025).²³ However, there is a lack of empirical evidence and “the quality of existing evidence is poor, particularly as it pertains to the most important outcome of patient safety.”²³ Overall, researchers have concluded there is “insufficient evidence to support widespread implementation of non-transport and alternative destination protocols” of patients to facilities other than EDs,²⁶ as the safety, effectiveness, and efficiency of alternative destination transport is unknown.^{22,23,26}

While some evidence suggests alternative destination transportation may benefit patient-centered care and operational efficiency, researchers have noted concerns related to “patient safety resulting from incorrect triage decisions, inadequate training, lack of formal partnerships between ambulance and supporting services, and insufficient evidence to support safe implementation or continued use” of alternative destination transportation.²³

Many researchers have indicated there is limited research related to outcomes of alternative destination transportation programs, including whether transporting patients to alternative destinations: impacts care for patients with emergent health conditions treated in the ED (i.e., by reducing overcrowding); impacts care for patients with non-emergent health conditions treated in clinics; impacts services received (e.g., ongoing care, access to primary care, social services) for patients with non-emergent health conditions; or reduces facility or patient costs.²¹ As part of the evaluation of ET3 Model pilot program, CMS was not able to evaluate how transporting patients to a location other than the ED may have impacted Medicare spending, all-cause hospitalizations, all-cause mortality, or all-cause ED visits due to the low number of patients participating in alternative destination transportation.²² Similarly, staff from DOH stated that some counties are transporting some patients to urgent care facilities under the policy statement, however the effectiveness of these transports is unknown (personal communication, DOH, February 2025).

Researchers have found mixed results related to EMS triage,^{23,30} and research has suggested there may be challenges to EMS personnel triaging patients to alternative destinations. As part of the 1999 to 2001 pilot program in King County, a study physician reviewed EMS determinations of patient eligibility for alternative destination transportation.²¹ The study physician determined that EMS personnel appropriately identified people as potentially eligible for care at an alternative destination in 97% of cases.²¹ However, the study authors emphasized that the inclusion criteria for alternative destination transportation were chosen “because they optimized safety and practicality (ease of EMT use)”²¹ They noted that expanding eligibility criteria may allow additional patients to be transported to alternative destinations but “expanding criteria may require EMTs to screen potentially higher-risk patients as well as be more work-intensive for EMTs.”²¹

As part of the CMS ET3 Model, patients participating in alternative destination transportation experienced high rates of ED follow-up visits.²² CMS noted that this suggests patients participating in alternative destination transportation may have had higher acuity of health concerns and “[h]ospitalizations following [alternative destination transportation] may have

resulted per direction of [alternative destination partners] or may have occurred because a [...] patient should have been triaged to an ED.”²² CMS found some uncertainty among EMS personnel to use treatment in place or to transport patients to a facility other than an ED.²² Specifically, EMS personnel reported not using ET3 options due to concerns about operational changes and procedures “compared to procedures in standard EMS response; concerns about patient out-of-pocket costs; or uncertainty about how to address questions from patients.”²² CMS stated that ambulance organizations noted that successful implementation of ET3 “required significant organizational resources, including relationship building with providers and payers; staff bandwidth; infrastructure and equipment; and training and retraining of EMS ambulance personnel.”²²

Two double-blinded studies have assessed the level of agreement between paramedic and emergency physician assessments of patient acuity during triage.^{26,42} One study found that, in 11.6% of cases, EMS under-triaged patients (i.e., assessed patients as lower acuity) compared to emergency physicians in their assessment of whether a patient could have been transported to an urgent care clinic rather than an ED.⁴² The authors stated that “[t]his is a relatively low, yet still unacceptably high, under-triage rate. This disagreement could lead to delay in care, with potential for a poor outcome by permitting EMS to transport to a lower level of care. [...] over-triage is preferred to prevent harm to the patient by transporting to a facility that provides a higher level of care.”⁴²

Similarly, researchers in California found a significant difference between paramedic assessment and emergency physician assessment of acuity during triage.²⁶ Paramedics assessed 8.9% of patient as higher acuity compared to emergency physicians and assessed 19.3% of patients as lower acuity, suggesting that EMS personnel may be more likely to assess a patient as lower acuity than emergency physicians.²⁶ The authors noted that the findings were consistent with previous research that has suggested “a wide range of rates (3% to 32%) of EMS personnel failing to recognize the severity of patients’ problems.”²⁶ Overall, the authors concluded that “field triage of a patient to an alternative destination by paramedics under their current scope of practice and training cannot be supported” as “many issues must be addressed to ensure the quality of alternative transportation and destination programs with patient safety as the utmost priority.”²⁶

Key informants in Washington State stated that there have been concerns about EMS ability to successfully triage patients who could be transported to healthcare facilities other than EDs (personal communication, DOH, February 2025). However, DOH staff stated that they were unaware of any triage concerns related to EMS transport to mental health facilities, chemical dependency programs, isolation and quarantine facilities, or Tribal clinics in the state (personal communication, DOH, February 2025).

Key informants expressed concern about EMS triaging patients to facilities other than EDs when they may be unaware of a patient’s health insurance status, insurance type, or ability-to-pay (personal communications, February 2025). Most key informants noted EMTALA guarantees access to emergency services regardless of a patient’s ability to pay in hospital settings (personal communications, February 2025). However, EMTALA’s patient protections do not apply to urgent care clinics unless they are affiliated with a hospital that falls under the law (personal

communications, February 2025). Key informants stated that transporting a patient to a facility that is not covered by EMTALA may result in delayed or denied care for patients who cannot afford to pay for services, required co-payments, etc. (personal communications, February 2025). Additionally, facilities may accept different forms of health insurance, which could impact whether patient care is covered by insurance. For further discussion of patient costs, see Additional Considerations on page 30.

Key informants also stated that facilities other than EDs may not offer the same services, which could also impact accurate triage (personal communications, February 2025). For example, urgent care clinics range from “mimicking a traditional office practice, while others offer emergency procedures, lab tests, electrocardiograms, diagnostic radiology, and even intravenous therapy.”⁴² Researchers have noted that, while urgent care clinics are ubiquitous in many areas, they “lack uniformity in levels of care they provide, and generally will only evaluate insured patients who do not need to pay steep up-front fees.”⁴² Key informants also stated that urgent care facilities in Washington State do not provide standard healthcare services, and there is variability in the level of services offered (personal communications, February 2025). This may present challenges in developing standardized transport procedures or in EMS consistently triaging to locations. EMS would need to be aware of what services a patient may need and match patient needs with services offered by a participating urgent care clinic, which could result in some patients not being transported to an appropriate location (personal communications, February 2025).

CMS also found that patient refusal contributed to low participation in alternative destination transportation. CMS noted, “given the potential risk to health, patients may have been uncertain whether these ED alternatives were legitimate and safe, or that the quality of services was similar to ED care.”²² In San Francisco, “patients felt apprehensive about being taken to an alternative clinic site with which they were unfamiliar,” resulting in patient refusals for alternative destination transportation.²⁵

A 2017 study recommended against implementation of alternative destination transportation due to concerns about “insufficient supporting evidence, under triage having an adverse impact on patient safety and vulnerable patients being disproportionately affected.”²³ Overall, since many researchers have noted there is limited and insufficient evidence related to alternative destination transportation, since there has been limited evaluation of how allowing ambulance service transport to facilities other than EDs may impact patient outcomes, and since it is unknown how facilities other than EDs may be able to meet patient care needs in Washington State, the impact of HB 1864 on health outcomes is not well-researched.

Additional considerations

This Health Impact Review focused on the most linear pathway between provisions in the bill and health outcomes. Evidence for how HB 1864 may impact reimbursement for ambulance services and costs for patients is discussed below.

Under current law, health carriers, public and school employee health plans, and Apple Health (Medicaid) programs provide coverage for medically-necessary ambulance transports.⁴⁴ Current coverage varies by health plan.⁴⁴ According to the Washington State Office of the Insurance

Commissioner (OIC), “[i]n most cases, transports to a hospital emergency department are covered by Apple Health (Medicaid), Medicare, and commercial health plans. For all other services, coverage varies depending upon the payer and its policies.”⁶ Alternative destination transportation is not covered by Medicare, may be covered by Apple Health if certain criteria are met, and is generally not covered by commercial healthcare plans.⁶

HB 1864 would direct health carriers, public and school employee health plans, and Apple Health to provide coverage for ambulance transport to facilities other than EDs, as authorized in the regional plans. [Chapter 48.43 RCW](#) impacts all fully-insured health plans in Washington State, including individual and small group/small employer plans offered on the Exchange and Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) government-sponsored plans (personal communication, HCA, February 2025). The provisions in the bill would not apply to self-insured plans (large employer plans), which must comply with federal laws and are not subject to state laws (personal communication, HCA, February 2025).

Almost all key informants stated that health carriers providing coverage for ambulance transport to facilities other than EDs would facilitate EMS transport to alternative facilities and reduce the cost burden on EMS (personal communications, February 2025).

Reimbursement for ambulance services

Key informants stated there is currently some disincentive to transport patients to facilities other than EDs (personal communications, February 2025). Generally, “[w]hile EMS provides a range of patient services, current reimbursement policies are structured such that EMS agencies must ultimately transport the patient to an [ED] for a service claim to be paid. There is no reimbursement for readiness, response, triage, patient assessment, or any treatment provided unless the patient is transported to a hospital.”³⁰ Many key informants in Washington State also stated there is an incentive for ground ambulances to transport to an ED because that is the only way they receive reimbursement (personal communications, February 2025).

While HB 1864 would require plans to provide coverage of transport to non-emergency facilities, non-emergency ambulance transport is currently reimbursed at a lower rate than emergency transport (personal communications, February 2025). HB 1864 does not address reimbursement parity for emergency and non-emergency transport (personal communications, February 2025). Key informants also stated that responses to 911 calls should be treated as emergency transport, regardless of whether the patient is transported to an ED or to another facility because the cost of preparedness (i.e., the cost of having an ambulance and EMS personnel ready to respond and responding to a call) is a fixed cost (personal communications, February 2025).

In addition, reimbursement rates for ambulance service providers may be lower if an alternative facility is closer than the nearest ED, which could disincentivize patient transport to alternative destinations (personal communications, February 2025). For example, “[m]ileage is a separate component of ground ambulance services and is usually paid separately from transport.”⁶ If an alternative destination is located closer than an ED, the ambulance service may receive lower reimbursement overall (based on mileage), thereby disincentivizing transport to the alternative destination (personal communications, February 2025). Research has also shown that EMS

transport may not be guided primarily by proximity.⁴⁵ One study found that factors like race/ethnicity, patient choice or preference, or clinical conditions may impact transport destinations,⁴⁵ which could also impact care received and cost of care.

Therefore, since HB 1864 does not address parity in reimbursement between non-emergent and emergent ambulance transport, there may still be disincentives to transport patients to facilities other than EDs. Since it is unknown how reimbursement provisions may impact transport to alternative facilities, this pathway was not included in the logic model on page 16.

Costs for patients

HB 1864 would direct health carriers, public and school employee health plans, and Apple Health to provide coverage for ambulance transport to facilities other than EDs, as authorized in the regional plans. Key informants stated that this change in coverage may have fiscal impacts for patients and impact rates (personal communication, OIC, February 2025).

It is unknown how transport to alternative facilities may impact patient costs. Generally, health plans cover emergency ambulance transport and specific coverage varies by plan.⁶ Transportation to a facility other than an ED “may be covered at varying levels by insurance carriers and can result in large cost-sharing and balance bills for patients.”⁶ For example, bills charged for non-emergency transport with Basic Life Support (BLS services) may range from \$840.09 to \$1,490.90 depending on type of insurance and whether care is in-network or out-of-network.⁶ Since coverage varies by health plan, HB 1864 may impact different plans differently (personal communication, OIC, February 2025).

Ground ambulance bill charges have increased over time for all ambulance services, including both in-network and out-of-network services and both emergency and non-emergency services.⁴⁵ Between 2017 and 2023, non-participating providers’ charges increased 69% for emergency services and 75% for non-emergency services.⁶ Increases in bill charges “largely falls on consumers who are balance billed for hundreds, if not thousands, of dollars and too often are unable to afford these additional charges, leading to medical debt and other serious financial and health repercussions.”⁶ Key informants stated that, while Senate Bill (SSB) 5986 ([Chapter 218, Laws of 2024](#)) prohibits out-of-network ambulance companies from sending a “balance bill” to patients who receive emergency medical treatment at the scene or are transported to an appropriate emergency service, Washington State’s balanced billing laws do not apply to non-emergency transport or urgent care clinics (personal communications, February 2025). Therefore, if a patient is dropped off at a facility that is out-of-network or receives care at an urgent care clinic, patients may receive higher medical bills for ambulance transport and healthcare services (personal communications, February 2025).

Additionally, alternative facilities may accept different forms of health insurance, which could impact whether patient care is covered by insurance. Key informants stated that EMS does not screen patients for insurance status or type of insurance; determine types of insurance accepted by alternative facilities; or determine which care options may be in-network or out-of-network (personal communications, February 2025). Key informants stated that this level of screening by EMS personnel in the field is not possible in emergency situations (personal communications, February 2025). Moreover, key informants stated that this type of screening may result in

inequities in care by insurance status or type of insurance (personal communications, February 2025).

EMTALA also does not include ground ambulance services.⁶ Key informants stated that EDs must adhere to EMTALA, but urgent care facilities are not legally required to provide care regardless of ability to pay, which could also impact patient costs (personal communications, February 2025).

Key informants also cautioned that if EMS personnel are not able to reliably track whether alternative facilities are available or if they are turned away from an alternative facility (closed, capacity, patient is assessed as higher acuity, etc.) and must double-transport a patient to an ED, patient costs may increase (personal communication, February 2025). For example, patients may be billed for transport to urgent care, care at urgent care, transport to an ED, care at an ED, and then a hospital admission bill, which could substantially increase patient costs (personal communications, February 2025).

Overall, HB 1864 may impact different health plans differently, and it is unknown how ability to pay may impact care received and cost of care if a patient is transported to a facility other than an ED. Therefore, since it is unknown how reimbursement provisions may impact costs for patients, this pathway was not included in the logic model on page 16.

Annotated References

- 1. Emergency Room Rights. 2024; Available at: <https://www.cms.gov/priorities/your-patient-rights/emergency-room-rights>. Accessed 2/17/2025.**

This CDC webpage provides an overview of patient rights created under the Emergency Medical Treatment and Labor Act (EMTALA).
- 2. Regional EMS and Truma Care Council Resource Handbook. In: Health WSDo, ed. Olympia, WA2019.**

This handbook was developed by the Washington State Department of Health's Office of Community Health Systems. It was developed to provide information on teh history and operations of the EMS and trauma caer system in Washington State. It provides federal, state, regional, and local context (history and responsibilities) as well as resources.
- 3. Consolidated Omnibus Budget Reconciliation Act of 1985, (1986).**

This U.S. Congressional webpage provides the legislative text of HR 3128.
- 4. About the Preventive Health and Health Services (PHHS) Block Grant. 2025; Available at: <https://www.cdc.gov/phhs-block-grant/about/index.html>. Accessed 2/19/2025.**

This CDC webpage provides information about the Preventive Health and Health Services (PHHS) Block Grant.
- 5. Emergency Medical Treatment & Labor Act (EMTALA). 2024; Available at: <https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act>. Accessed 2/17/2025.**

This CDC webpage provides an overview of the U.S. Emergency Medical Treatment & Labor Act (EMTALA).
- 6. Commissioner Office of the Insurance. Ground Ambulance Balance Billing Study: Legislative Study Report.2023.**

During the 2022 Legislative Session, the Washington State Legislature passed E2SHB 1688, which directed the Office of the Insurance Commissioner (OIC), in collaboration with the Department of Health and Health Care Authority, to submit a report to the Legislature about how to prevent balance billing for ground ambulance services. OIC convened a Ground Ambulance Balance Billing Advisory Group. This report was submitted to the Legislature in October 2023.
- 7. The Emergency Medical Treatment and Labor Act (EMTALA). 2024; Available at: <https://oig.hhs.gov/reports/featured/emtala/>. Accessed 2/17/2025.**

This U.S. HHS, Office of the Inspector General (OIG) webpage provides an overview of EMTALA, enforcement by the HHS-OIG, enforcement procedures, and enforcement actions.
- 8. Shulkin David J. Inter-Facility Transfer Policy. In: Affairs DoV, ed. Washington, DC2024.**

The Veterans Health Administration (VHA) Directive 1094(1) addresses its inter-facility transfer policy. The policy states that while the VA mecial facility ED or Urgent Care Clinics are not technically subject to the Emergency Medical Treatment and Labor Act (EMTALA), the VHA

requires as a matter of policy that VA staff comply with the intent of EMTALA regarding the transfer of patients seen in VA ED/UCCs.

9. **WAC 182-546-0125 Ambulance transportation—Definitions. In: Authority WSHC, ed. *Washington Administrative Code*. Olympia, WA2020.**

This section of the Washington State Health Care Authority's Administrative Code defines various types of ambulance transportation.

10. **RCW 74.70.020 - Definitions (*contingent expiration date; expires July 1, 2028*). (2020).**

This section of RCW defines terms used in the Ambulance Transport Fund.

11. **RCW 18.73.030 - Definitions, (2023).**

This section of RCW defines terms used in the Emergency Medical Care and Transportation Services Chapter 18.73 RCW.

12. **EMS and Trauma. Available at: <https://doh.wa.gov/public-health-provider-resources/emergency-medical-services-ems-systems/ems-and-trauma/history-and-background>. Accessed 2/14/2025.**

This DOH webpage provides historical background on the state's EMS and Trauma systems including key actors and state authority and responsibilities.

13. **Emergency Medical Services and Trauma Care Steering Committee. Available at: <https://doh.wa.gov/public-health-provider-resources/emergency-medical-services-ems-systems/ems-and-trauma/councils-and-committees/ems-and-trauma-steering-committee>. Accessed 2/12/2025.**

This DOH webpage provides an overview of the EMS and Trauma Care Steering Committee, its membership, and responsibilities.

14. **Regional EMS and Trauma Resources. Available at: <https://doh.wa.gov/public-health-provider-resources/emergency-medical-services-ems-systems/ems-and-trauma/councils-and-committees/regional-ems-and-trauma-resources>. Accessed 2/12/2025.**

This DOH webpage details information about the Regional EMS and Trauma resources including the Regional EMS and Trauma Council membership and information about regional plans.

15. **EMS and Trauma Publications. Available at: <https://doh.wa.gov/public-health-provider-resources/emergency-medical-services-ems-systems/ems-and-trauma/publications>. Accessed 2/12/2025.**

This DOH webpage provides a list of publications including EMS and Trauma Care Clinical Guidelines, Regional Plans, etc.

16. **Final Bill Report SSB 5986. In: Services SC, ed. Olympia, WA2024.**

This Final Bill Report from Senate Committee Services staff provides a brief synopsis of Substitute Senate Bill (SSB) 5986 (Chapter 218, Laws of 2024) as enacted.

17. **Notice of Adoption of a Policy Statement: EMS Transport to Appropriate Alternative Medical Facilities | Policy Number: EMS 21-02. In: Health WSDo, ed. Vol WSR 22-01-044. Olympia, WA: Washington State Office of the Code Reviser; 2021.**

This DOH Policy Statement released by the Health Systems Quality Assurance Office of Community Health Systems' EMS Section outlines under what conditions licensed Emergency Medical Services may transport patients to appropriate alternative medical facilities: including state or federally established alternative care facilities (ACFs); isolation or quarantine facilities established by local health jurisdictions; Tribal health clinics and Indian Health Services (IHS) Facilities; and urgent care facilities established and managed by licensed hospital systems.

18. **RCW 71.24.916 - 23-hour crisis relief centers—Licensing and certification—Rules—Standards, (2023).**

This RCW established Washington's 23-hour crisis relief centers licensing and certification rules and standards. The Legislature initially authorized the creation of these centers for adults (Chapter 433, Laws of 2023) and expanded the authority to include service for children the following year (Chapter 267, Laws of 2024).

19. **AHCCCS Medical Policy Manual | Chapter 300 - Section 310 -- Covered Services. In: System AHCCC, ed2024.**

The Arizona Health Care Cost Containment System's Chapter 300, Section 310, BB - Transportation policy identifies Alternative Destination Partners to include an AHCCCS registered provider, such as a Federally Qualified Healthcare Center/Rural Health Clinic (FQHC/RHC), primary care doctor, specialist, behavioral health center or urgent care clinic.

20. **Two Hinchey Bills to Strengthen EMS and Expand Emergency Care Signed into Law. 2024; Available at: <https://www.nysenate.gov/newsroom/press-releases/2024/michelle-hinchey/two-hinchey-bills-strengthen-ems-and-expand-emergency#:~:text=Previously%2C%20EMS%20was%20only%20reimbursed,situations%2C%20not%20just%20between%20hospitals>. Accessed 2/15/2025.**

This press release from New York State Senator Michelle Hinchey's office announced passage of state legislation to create new avenues for EMS reimbursement.

21. **Schaefer R.A., Rea T.D., Plorde M., et al. An Emergency Medical Services Program of Alternate Destination of Patient Care. *Prehospital Emergency Care*. 2002;6(3):309-314.**

Schaefer et al. conducted a pilot program with 2 fire agencies in King County, Washington from December 1999 through January 2001 to determine whether alternate destination transportation by EMS could decrease the use of the ED by patients with non-urgent care needs. The program was conducted in two phases. Phase I of the program was used to validate patient inclusion criteria for non-urgent care, to identify alternative care destinations, and to train staff. Phase II of the program identified patients who met inclusion criteria to receive alternative care and offered patients an alternative care destination. Four alternate care destinations participated in the program, including urgent care clinics, walk-in clinics, and office-based provider practices that accepted walk-in patients. Destinations were required to have on-site physician staff, laboratory capabilities, and x-ray capabilities. As part of Phase I, EMS personnel identified patients as potentially eligible for an alternative care destination, but continued to transport patients to the ED. Review by the study physician determined that EMS personnel appropriately identified

people as potentially eligible for alternative care in 97% of cases. During the program, the 2 fire agencies received 5,724 basic life support-related calls and 1,016 calls (18%) met the eligibility criteria for alternative destination transportation. Eighty-one (81) patients (0.80% of eligible calls; 0.14% of all calls) were referred to and treated at an alternate care destination. The median length of visit for patients transferred to an alternate destination for care was 1 hour (range 30 minutes to 4 hours). Five patients were initially referred to an alternate care destination before transport to the ED. The authors found no decrease in ED use or increase in clinic use among nonparticipating agencies. The study authors also evaluated “why the ED was used despite clinic eligibility.” They found the most common reasons for ED use despite clinic eligibility were patient preference and clinics being closed. Other reasons included that the EMT decided ED care was more appropriate based on situational or medical comorbidity and the clinic requesting the patient go to the ED for medical reasons (e.g., clinic judged patient should be treated in the ED); and the clinic requesting the patient go to the ED for logistical reasons (e.g., clinic too busy). Overall, the authors found that alternative destination transportation “for specific low-acuity diagnoses was associated with a 15% relative decrease in the proportion of patients who received care in the ED” compared to historical and contemporary control groups. The 15% decrease in ED usage correlated with an 80% increase in the proportion of patients who received care at a clinic, and both changes were statistically significant. The authors found that “the program of alternate care destinations was responsible for the decrease in ED visits and the increase in clinic visits.” The authors stated that only 18% of patients met eligibility criteria and “for EMS to further decrease the volume of nonurgent ED visits, one could expand the eligibility criteria or address the obstacles to clinic transport among the currently-eligible patients. The eligibility criteria were chosen because they optimized safety and practicality (ease of EMT use); expanding eligibility criteria may require EMTs to screen potentially higher-risk patients as well as be more work-intensive for EMTs. Alternatively, the major reasons for ED care despite clinic eligibility were patient preference and limited clinic hours, which together accounted for 80% of eligible patients not referred to an alternate care destination.” The authors also note the importance of assuring a standard of care at alternate destinations. Lastly, the authors stated that no evaluation was completed to determine “whether the program actually improved care of more acute ED patients, facilitated ongoing or primary care of nonurgent patients, or decreased costs.” Previous research has shown that up to half of patients who receive care in the ED are treated for non-emergent conditions that could be appropriately treated in less emergent settings. Research has suggested that use of ED for non-emergent care may be due to lack of a regular healthcare provider, lack of access to healthcare, lack of insurance coverage, convenience, and patient preference. The authors also summarized research that “the use of the ED for nonurgent health needs can contribute to ED overcrowding, a situation that may jeopardize patients’ health by diverting or delaying health resources for the most acute patients. Moreover, the delivery of care for nonurgent conditions in the ED may cost more compared with that in other medical settings.” In addition, patients treated for nonurgent conditions in the ED may not receive preventive healthcare or services that may be available in other healthcare settings.

22. (CMS) Centers for Medicare & Medicaid Services. Emergency Triage, Treat, and Transport (ET3) Model: Final Evaluation Report. Center for Medicare and Medicaid Innovation, Centers for Medicare & Medicaid Services;2025.

In January 2025, the Centers for Medicare and Medicaid Services (CMS) published the final evaluation report of a voluntary Emergency Triage, Treat, and Transport (ET3) Model for people

enrolled in Medicare. The ET3 Model allowed ground ambulance providers to provide treatment in place or alternative destination transportation to eligible Medicare patients who agreed to participate in an ET3 option. CMS conducted the ET3 Model from January 1, 2021 through December 31, 2023. For ambulance providers participating in ET3, EMS determined whether a patient was eligible to be treated in place or transported to a location other than the ED. Patient transport was allowed to an urgent care clinic, a federally-qualified health center, an outpatient clinic, or another approved location. CMS evaluated the impact of the ET3 Model based on 4 outcomes: 1) Medicare spending; 2) All-cause hospitalization; 3) All-cause mortality; and 4) All-cause ED visits. Overall, 185 ambulance organizations participated in ET3. However, only 38% of ambulance organizations that participated in ET3 used treatment in place or alternative destination transportation. CMS found low overall participation in treatment in place or alternative destination transportation, with ET3 options made up less than 1% (on average) of an ambulance organization's annual Medicare ambulance transports. Treatment in place accounted for 92% of ET3 interventions. Only 257 patients participated in alternative destination transportation. CMS summarized themes related to low use of ET3 options and identified challenges related to COVID (i.e., perception of clinic capacity); patient refusal for treatment in place or transport to an alternative destination; avoidance of ET3 options by EMS and ambulance services due to unfamiliarity with operational procedures; difficulty obtaining agreements with alternative destination partners; limited capacity or availability of alternative destination partners to receive patients; concerns from alternative destination partners; and EMS disengagement. CMS noted, “[p]atients in an emergency medical situation tended to avoid departing from typical EMS care in an ED because of unfamiliarity with [treatment in place and alternative destination transportation] services. Given the potential risk to health, patients may have been uncertain whether these ED alternatives were legitimate and safe, or that the quality of services was similar to ED care.” Similarly, “health care providers tended to avoid [treatment in place and alternative destination transportation] because of unfamiliarity or uncertainty with these arrangements.” Some healthcare providers expressed uncertainty about the legitimacy of the ET3 options and some “were concerned about operational risks such as receiving acutely ill patients they were not equipped to manage, not knowing when patients would arrive, or the potential that patients would need transportation back to their residence.” In addition, CMS found some uncertainty among EMS personnel to use treatment in place or to transport patients to a location other than the ED. Specifically, EMS personnel reported not using ET3 options due to concerns about operational changes and procedures “compared to procedures in standard EMS response; concerns about patient out-of-pocket costs; or uncertainty about how to address questions from patients.” CMS emphasized that the “combination of difficulty obtaining agreements with Alternative Destination Partners (ADPs) and limited ADP availability and capacity to accept [alternative destination transportation] patients was seen as the primary challenge that limited” the use of alternative destination transportation. Partners were concerned about capacity (e.g., due to COVID), legality, and operational procedures. Among ambulance organizations that implemented ET3, CMS found that successful implementation of ET3 did not vary due to organization size, type of organization (e.g., fire departments, private ambulance services), or geographic location (i.e., urban or rural) Rather, successful implementation was due to a commitment to implement ET3. Among patients participating in alternative destination transportation, the most common health conditions were injury or poisoning; mental or behavioral disorders; and musculoskeletal system conditions. 41% of patients participating in alternative destination transportation were Medicaid patients who had a disability and high rates

of severe mental illness (e.g., depression, schizophrenia, bipolar disorder; alcohol use disorder). Patients that participated in alternative destination transportation were more likely to be transported to the ED than patients receiving treatment in place options, suggesting these patients may have had higher clinical acuity. Specifically, 7% of patients who participated in alternative destination transportation were transported to the ED on the same day and 24.5% were transferred to the ED within 5 days (compared to 1.8% and 11.5%, respectively, of patients participating in treatment in place). While use of ET3 options were overall low, CMS concluded that “[a]ssuming that an ED visit would have occurred absent [treatment in place or alternative destination transportation], these interventions may have been associated with between 70[%] and 85[%] fewer ED visits.” Due to the small number of patients participating in alternative destination transportation, CMS was not able to evaluate how transporting patients to a location other than the ED may have impacted Medicare spending, all-cause hospitalizations, all-cause mortality, or all-cause ED visits. CMS concluded, “[i]n theory, the ET3 Model appears to have some potential as a component of a broader strategy to reduce population reliance on EDs as a primary access point for health services. [...] However, the experience of the ET3 model showed that [...] delivery of ET3 interventions were severely limited by challenges to ET3 implementation and delivery.” CMS stated that ambulance organizations noted that successful implementation of ET3 “required significant organizational resources, including relationship building with providers and payers; staff bandwidth; infrastructure and equipment; and training and retraining of EMS ambulance personnel.”

23. Blodgett J. M., Robertson D. J., Pennington E., et al. Alternatives to direct emergency department conveyance of ambulance patients: a scoping review of the evidence. *Scand J Trauma Resusc Emerg Med.* 2021;29(1):4.

Blodgett et al. conducted a scoping review of 41 articles published through February 2020 related to alternative destination transportation. The authors hypothesized that they would find low-quality and limited evidence for how alternative destination transportation impacts patient outcomes. Of studies included in the review, 18 were evidence-based quantitative studies (including 4 conducted in the U.S.), 12 were qualitative studies (including 1 conducted in the U.S.), and 11 were consensus-based articles (including 6 conducted in the U.S.). U.S.-based quantitative studies found a need for: 1) additional triage support (e.g., use of both telephone/telehealth triage and on-scene triage; improved or refined triage tool) to ensure appropriate triage by EMS and 2) additional evaluation to determine appropriateness of care received at alternative destinations.

24. Creed J. O., Cyr J. M., Owino H., et al. Acute Crisis Care for Patients with Mental Health Crises: Initial Assessment of an Innovative Prehospital Alternative Destination Program in North Carolina. *Prehosp Emerg Care.* 2018;22(5):555-564.

Creed et al. evaluated EMS transport to community mental health and substance use disorder treatment facilities in North Carolina from August 2013 through July 2014. If paramedics determined a patient was experiencing an acute mental health or substance use disorder crisis, met intake criteria, and was not experiencing other health conditions, they could provide alternative transport to a dedicated community mental health facility offering a 24/7 crisis unit, inpatient psychiatric care, residential treatment, and alcohol and substance detoxification. Patients were transported to an ED if the patient did not meet criteria, requested transport to an ED, or refused transport to the community mental health facility or another alternate location, or

if the facility indicated they were at capacity. During the study period, 1,555 patients met inclusion criteria. About 60% (937 patients) did not meet protocols and were not eligible for alternative transportation and about 15% (232 patients) were eligible, but refused alternative transportation. Overall, about 25% (388 patients) were eligible for alternative transportation and accepted transport to an alternative location, including 223 patients (14%) who were transported to the dedicated community mental health facility and 165 (11%) patients who were transported to another alternative facility. Overall, 220 patients who were transported to the dedicated community mental health facility and had complete data were included in the final study group. About 45% of these patients were diagnosed with a mental disorder, 6% with a substance use disorder, and 36% with a co-occurring mental and substance use disorder. No diagnosis was available for 13% of patients “due to patients refusing services or requiring transfer to an ED.” Overall,40% of patients who were transported to the community mental health facility “were exclusively treated and stabilized” at the facility and discharged home. About 9% of patients initially transported to the community mental health facility were transferred to an ED, with over half being transferred within 4 hours of arrival at the community mental health facility. Another 4% of patients were transferred to the ED after being admitted to the community mental health facility. Over a 30-day follow-up period, 27% of patients had a return visit to the community mental health facility or an ED, which is higher than average ED follow-up (19.8%); 23% of return visits were to the community mental health facility and 77% of return visits were to an ED.

25. Berger D., Wong-Castillo J., Seymour R., et al. Feasibility and Safety of a Field Care Clinic as an Alternative Ambulance Destination during the Covid-19 Pandemic. *Int J Paramed.* 2023;1(1):73-84.

During the COVID-19 pandemic, San Francisco Department of Public Health developed neighborhood Field Care Clinics and allowed EMS transport for patients with low-acuity health concerns to clinics to reduce strain on EDs. Berger et al. evaluated patients transported to one Field Care Clinic from April 11, 2020 to December 16, 2020. The authors found that, “[a]fter excluding transports that occurred outside of the [Field Care Clinic’s] operating hours, 18,081 transports were potentially eligible for [transport to the Field Care Clinic]” [...]. However, the [Field Care Clinic] was recommended as a destination only 48 times.” Overall, only 35 patients were transported by EMS to the Field Care Clinic (0.3% of all transports), with most occurring within the first 3 months of implementation. About 34% (12 patients) required subsequent transport to an ED. The authors stated that the hours of the Field Care Clinic may have been a main reason for underutilization as about half of EMS calls occurred outside of the Field Care Clinic hours of operation. They noted that protocols at the Field Care Clinic meant that “[h]ours of operation could vary, making it difficult for EMS clinicians to know if the [clinic] was open to receiving patients.” This resulted in a “narrative of patient offload delays at the clinic compared to the emergency department” and “EMS clinicians were never in a situation where an existing ED was not available to accept their patients, perpetuating the use of routine, rather than novel processes.” Other reasons may have been unfamiliarity with the Field Care Clinic by physicians and paramedics; lack of routine consideration for alternative destination transportation; no requirement for transportation to an alternative destination; limited EMS experience with alternative destination transportation; and lack of buy-in from EMS agencies. The authors also noted that “patients felt apprehensive about being taken to an alternative clinic site with which they were unfamiliar” and had concerns about transportation back to their neighborhood after

receiving treatment, resulting in patient refusals for alternative destination transportation. The study authors noted that “the underutilization of the [Field Care Clinic] by EMS as a transport destination and a high hospital transfer rate indicates training and protocol refinement opportunities. Despite the small cohort size, this study demonstrates that an [...] alternative care site can act as a viable source for urgent and emergency care during a pandemic.”

26. Neeki M. M., Dong F., Avera L., et al. Alternative Destination Transport? The Role of Paramedics in Optimal Use of the Emergency Department. *West J Emerg Med.* 2016;17(6):690-697.

Neeki et al. conducted a prospective double-blinded analysis to determine whether EMS could accurately determine whether a patient should be transported to the ED. The study occurred in California between April 2015 and November 2015. Paramedics and emergency physicians assessed the acuity of 503 patients. Neeki et al. analyzed and compared the assessments to determine the level of agreement between paramedic and emergency physician assessments of acuity. For the 503 patients, paramedics assessed 251 patients (49.9%) as emergent (i.e., requiring immediate care with threat of life), 178 (35.4%) as urgent (i.e., requiring immediate care without threat of life that could go to a facility other than the ED), and 74 (14.7%) as non-emergent/non urgent (i.e., not requiring transportation). For the same group of patients, emergency physicians assessed 296 patients (58.9%) as emergent, 148 (29.4%) as urgent, and 59 (11.7%) as non-emergent/non-urgent. Overall, paramedics agreed with emergency physicians about the acuity of patients in 71.8% of cases, suggesting moderate inter-rater reliability. The difference between paramedics and emergency physician assessments of acuity was statistically significant. Overall, the over-triaged (i.e., paramedics assessed a patient as higher acuity than emergency physicians) rate was 8.9% and the under-triage (i.e., paramedics assessed a patient as lower acuity than emergency physicians) rate was 19.3%, suggesting that EMS are more likely to assess a patient as lower-acuity. The authors concluded that, “field triage of a patient to an alternative destination by paramedics under their current scope of practice and training cannot be supported.” The authors noted that the findings of this study are consistent with previous research that has suggested “a wide range of rates (3% to 32%) of EMS personnel failing to recognize the severity of patients’ problems.” The authors stated that “many issues must be addressed to ensure the quality of alternative transportation and destination programs with patient safety as the upmost priority.” The authors noted some challenges to the study. For example, paramedics and physicians may engage in conversation during patient transfer that may influence assessment of acuity and patient symptoms may evolve from the time of field triage to care in the ED. The authors were also unable to verify acuity assessments by paramedics or by emergency physicians with actual patient outcomes or diagnoses. The authors recommend that alternative destination transportation include education for EMS personnel; programs to ensure coordination and compliance between various parts of the EMS system, including with community providers; protocols to ensure decisions are consistent with medical necessity, patient preference, and patient condition; and oversight and supervision of paramedics decision-making for alternative destinations.

27. Final Bill Report SHB 1721. In: Research OoP, ed. Olympia, WA2015.

This Final Bill Report from the House Office of Program Research staff provides a brief synopsis of Substitute House Bill 1721 (Chapter 157, Laws of 2015), Concerning the transport of patients by ambulance to facilities other than hospitals.

28. EMS Guideline Transport to Behavioral Health Facilities. In: Health WSDo, ed. June 2024 ed. Olympia, WA2024.

This EMS Guideline from the WA DOH's Office of Emergency Care Systems provides direction to regional EMS & trauma care councils for developing patient care procedures (PCPs), local EMS councils with developing county operating procedures, and EMS physician medical program directors (MPDs) in developing their prehospital patient care protocols for EMS transport to behavioral health facilities (inclusive of mental health and substance use disorder [SUD] facilities and services).

29. Multiple Agency Fiscal Note HB 1864, Ambulances/transport options. 2/13/2025 ed. Olympia, WA2025.

The Partial Fiscal Note published on February 13, 2025, includes information from the Office of the Insurance Commissioner (OIC) and Department of Health (DOH), but does not include information from Health Care Authority.

30. Munjal K. G., Shastry S., Loo G. T., et al. Patient Perspectives on EMS Alternate Destination Models. *Prehosp Emerg Care.* 2016;20(6):705-711.

Munjal et al. conducted a convenience sample of 621 patients and caregivers presenting to an ED in New York City between July 2012 and May 2013 to assess “patient attitudes, perspectives, and agreement/comfort with alternate destinations and other proposed innovations in [EMS] care delivery.” The authors read 13 statements and asked patients and caregivers their level of agreement based on a 5-point Likert scale. About “63% of respondents agreed or strongly agreed that EMS should have the option to transport patients to alternative destinations (clinic, primary care office, urgent care) and nearly as many (61.8%) agreed or strongly agreed that they would prefer the alternate destination option to the current standard of transport to the [ED] if determined to be appropriate.” The authors found slightly lower levels of support among Black and Hispanic participants, but noted that “[a]greement was relatively consistent among a diverse group of patients with varying demographics, levels of acuity, and EMS utilization history.”

31. Chapter 70.168 RCW - Statewide Trauma Care System.

This chapter of the Revised Code of Washington addresses the Statewide Trauma Care System.

32. Substitute House Bill 1721, Revised Code of Washington(2015).

Substitute House Bill 1721 established allowable transport of patients by ambulance to facilities other than hospitals including mental health facilities and chemical dependency treatment programs.

33. Council Central Region EMS and Trauma Care. Central Region EMS and Trauma Care System Plan (July 1, 2023 - June 30, 2025). 17 May 2023 ed2023.

The Central Region EMS & Trauma Council's Plan (FY 2024-2025) includes Appendix 9 documenting the Region's adopted Patient Care Procedures which were updated in November 2022 and approved on March 21, 2023. Prehospital Triage and Destination Procedures 5.4 (Mental Health and Chemical Dependency Destination Procedure - pg. 19) and 5.5 (Prehospital Triage and Destination Procedure - Other - pg. 20) indicate the region does not have these specific PCPs. However, the plan does include a Region Specific PCP for Adapt Clinic and

Urgent Care Clinic Transportation Policy (pg. 30) to provide guidance for prehospital personnel about patient transport to urgent care clinics.

34. Council East Region EMS and Trauma Care. East Region Emergency Medical Services and Trauma Care Council Strategic Plan (July 1, 2023 - June 30, 2025). May 2023 ed2023.

The East Region EMS & Trauma Council's Plan (FY 2024-2025) was approved by the EMS & Trauma Steering Committee in May 2023. The plan includes Appendix 9 documenting the Region's adopted Patient Care Procedures which includes Prehospital Triage and Destination Procedures 5.4 Mental Health and Chemical Dependency Destination Procedure outlined on pg. 57. It states, in the East Region, "licensed EMS ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, if approved by their county Medical Program Director (MPD)." General procedures are outlined within the PCP.

35. Council North Region EMS & Trauma Care. North Region Emergency Medical Services & Trauma Care Council Strategic Plan (July 1, 2023 - June 30, 2025). May 2023 ed2023.

The North Region EMS & Trauma Council's Plan (FY 2024-2025) was submitted May 17, 2023. The plan includes Appendix 9 documenting the Region's adopted Patient Care Procedures which details Prehospital Triage and Destination Procedures including 4.3 Mental Health and Chemical Dependency Destination Procedure outlined on pg. 61. It states, "the overall goal of this [PCP] is to reduce the potential misuse of EMS and hospital emergency room services" and procedures are designed to meet the objective of providing "clear instructions for developing operational guidelines to operationalize transport of patients from the field directly to mental health and chemical dependency facilities."

36. Council North Central Region EMS and Trauma Care. North Central Region Emergency Medical Services & Trauma System Strategic Plan (July 1, 2023 - June 30, 2025). 2023.

The North Central Region EMS and Trauma Council's Plan (FY 2024-2025) was approved by the EMS & Trauma Steering Committee in May 2023. The plan includes Appendix 9 documenting the Region's adopted Patient Care Procedures which includes Prehospital Triage and Destination Procedures 5.4 Mental Health and Chemical Dependency Destination Procedure outlined on pg. 58. It states, in the North Central Region, "licensed EMS ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, if approved by their county Medical Program Director (MPD)." General procedures are outlined within the PCP.

37. Council Northwest Region EMS and Trauma Care. Northwest Region Emergency Medical Services & Trauma Care System Plan (July 1, 2023 - June 30, 2025). 2023.

The Northwest Region EMS and Trauma Council's Strategic Plan (FY 2024-2025) was approved by the DOH Council on May 11, 2023. The Plan includes Appendix 9 documenting the Region's adopted Patient Care Procedures (PCPs). The approved PCPs do not include reference to the Mental Health and Chemical Dependency Destination Procedure.

38. Council South Central Region EMS & Trauma Care. South Central Region EMS & Trauma Care System Plan (July 1, 2023 - June 30, 2025). 2023.

The South Central Region EMS & Trauma Council's Plan (FY 2024-2025) was approved by the EMS & Trauma Steering Committee on May 17, 2023. The plan includes Appendix 9 documenting the Region's adopted Patient Care Procedures. The Region's PCP 5.4 Mental Health and Chemical Dependency Destination Procedure (outlined on page 22) was approved by the Council 5/28/2020. It states, "licensed ambulances may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170." General procedures are outlined within the PCP.

39. Council Southwest Region EMS & Trauma Care. Southwest Region EMS & Trauma Care System Plan (July 1, 2023 - June 30, 2025). 2023.

The Southwest Region EMS & Trauma Council's Plan (FY 2024-2025) was approved by the WA EMS & Trauma Steering Committee on May 17, 2023. The plan includes Appendix 9 documenting the Region's adopted Patient Care Procedures. The Region's PCP 5.4 Mental Health and Chemical Dependency Destination Procedure (outlined on page 46) was approved by the Council 7/1/2020. It states, "licensed ambulances may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170." General procedures are outlined within the PCP.

40. Council West Region EMS & Trauma Care. West Region Emergency Medical Services & Trauma Care System Strategic Plan (July 1, 2023 - June 30, 2025). 2023.

The West Region EMS & Trauma Council's Plan (FY 2024-2025) includes Appendix 9 documenting the Region's adopted Patient Care Procedures. PCP 11 Mental Health/Chemical Dependency Alternative Destination Transport Procedure (outlined on page 109) was last reviewed by the Council 3/6/2019. It states, In the West Region "licensed EMS ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, if approved by their county Medical Program Director (MPD)." Procedures are outlined within the PCP. The Council established a timeline (as of December 6, 2017) by which the MPD and local EMS and Trauma Care Council must develop a county operating procedures.

41. Medical Program Director Handbook. In: Health WSDo, ed. 4th ed. Olympia, WA2006.

The Washington State Department of Health's Office of EMS and Trauma System's Medical Program Director (MPD) Handbook addresses MPDs duties and responsibilities, legal issues, quality improvement program for MPDs, as well as links to additional information to guide work (e.g., history of EMS, statutes and rules, forms and certifications).

42. Carroll G., Levy K., Pescatore R., et al. Examination of EMS Decision Making in Determining Suitability of Patient Diversion to Urgent Care Centers. *Healthcare (Basel)*. 2019;7(1).

Carroll et al. conducted a double-blind survey from July 5, 2016 to August 11, 2016, with EMTs transferring care of patients to an ED and emergency physicians to examine their ability to decide if patients could be transported to an urgent care center. The authors recorded responses for 235 patient encounters and examined the level of agreement between EMTs and emergency

physicians in response to the question, “Could this patient have been diverted to an urgent care center?” Based on survey responses, EMTs identified 45 patients eligible for transport to an urgent care center. EMT and emergency physician assessments were in agreement 85% of the time. In 11.6% of cases, EMTs under-triaged (i.e., evaluated patients as lower acuity) than emergency physicians. The authors stated that “[t]his is a relatively low, yet still unacceptably high, under-triage rate. This disagreement could lead to delay in care, with potential for a poor outcome by permitting EMS to transport to a lower level of care. [...] over-triage is preferred to prevent harm to the patient by transporting to a facility that provides a higher level of care.” Overall, the authors found that urgent care centers “may be an alternative option for EMS transport, however strict protocols with medical direction are needed.” In 2019, at the time of this study, urgent care centers offered “expedited access to a healthcare provider and medical services to patients with non-life or limb threatening medical concerns. Ninety-six percent of [urgent care centers] are open [7] days a week and at least [4] hours a day.” The authors noted that, while urgent care centers are ubiquitous in many areas, they “lack uniformity in levels of care they provide, and generally will only evaluate insured patients who do not need to pay steep up-front fees.” The authors noted that ambulance transportation to urgent care centers “as been restricted by the complexity and rigidity of clinic schedules, non-standardized capabilities of [urgent care centers], and regulatory restrictions, including restricted insurer payments when patients are not transported to EDs.” Urgent care centers range from “mimicking a traditional office practice, while others offer emergency procedures, lab tests, electrocardiograms, diagnostic radiology, and even intravenous therapy.”

43. Bismah V., Prpic J., Michaud S., et al. rEDirect: Safety and compliance of an emergency department diversion protocol for mental health and addictions patients (Abstract only). *Canadian Association of Emergency Physicians*. 2019;21(Supplement 1):S43.

Bismah et al. evaluated a Canadian pilot program from June 1, 2015 to May 31, 2016 that allowed paramedics to transport people who are intoxicated or experiencing mental health concerns to a facility other than the ED. Out of 1,376 intoxication or psychiatric-related calls, 241 (17.5%) met eligibility criteria for alternative destination transportation. Of those, 158 patients (12.9%) were transported to a facility other than an ED and 84 (4.6%) were transported to an ED. Nine patients (5.6%) who were transported to a facility other than the ED were subsequently transported to the ED within less than 48 hours. The authors concluded that the alternative destination transportation pilot program has the potential to divert 1 in 6 patients experiencing intoxication or mental health concerns to a facility other than the ED.

44. Washington State House of Representatives Office of Program Research. Bill Analysis: HB 1864, Transporting patients by ambulance to facilities other than emergency departments. 2025.

This Bill Report provides relevant background information and a summary of bill provisions for HB 1864.

45. Hanchate A. D., Paasche-Orlow M. K., Baker W. E., et al. Association of Race/Ethnicity With Emergency Department Destination of Emergency Medical Services Transport. *JAMA Netw Open*. 2019;2(9):e1910816.

Hanchate et al. conducted a retrospective cohort study of Medicare claims data for 864,750 people enrolled in Medicare from January 1, 2006 to December 31, 2012, in 4,175 zip codes (accounting for 34.1% of people nationally enrolled in Medicare) who had used EMS transport to the ED. The authors evaluate the patterns of EMS transport to EDs by patient race/ethnicity. The authors stated 2 conclusions. First, Black and Hispanic Medicare enrollees were less likely than white Medicare enrollees to be transported to the most frequent ED destination. Second, Black and Hispanic Medicare enrollees were more likely to be transported to a safety-net hospital compared to white enrollees, “which often involved bypassing several zip codes.” The authors stated that ED “destination is substantially different on the basis of race/ethnicity of patients living in the same zip code”, suggesting that EMS transport may not be guided primarily by proximity. It is unclear what role patient choice or preference or clinical conditions may have in ED destination.