a joke. I had to verify it multiple times [...] What a ridiculous incentive."[127]

Recommendations—Alternative destinations will not always be the appropriate destination—often that will remain a hospital emergency room—but especially for situations involving simpler cases and non-medically emergent issues, they can represent a potentially valuable tool for crisis responders. In particular, policies that prohibit or discourage alternative destination transport by EMS can inhibit pre-arrest diversion and undercut crisis response by forcing law enforcement to serve as the only possible transporters to these alternative destinations. If law enforcement is unable or unwilling to take the time to transport an individual to an alternative destination, the only remaining options may be transport to an emergency department or a police station. In either instance, the effectiveness of the crisis response may suffer. As such, jurisdictions should adopt policies that allow for the considered and appropriate use of alternative destination transport by EMS.[128]

Although prescriptive language is the most straightforward way for policymakers to expand the availability of alternative destinations, additional clarity is also important. As this survey shows, a failure to address destinations clearly—or at all—in statute, as well as a delegation of the issue to local authorities, can leave the legal status of alternative destinations unclear. For example, one study that interviewed EMS directors and representatives in all fifty states on their perceptions of their legal prerogatives found only 40 percent concordance between the researchers' findings on EMS boards' ability to expand alternative destinations and what EMS representatives believed was permissible.[129] The remedy to this problem is twofold: legislators should work to ensure the law directly and clearly permits alternative destinations, and authorities should work to resolve ambiguities in current law and educate relevant stakeholders about the potential availability of alternative destinations.

Finally, ensuring that alternative destinations are not only legally permissible but also actually used requires addressing the collateral issue of costs. Ambulance providers are unlikely to utilize alternative destinations—at least with any degree of frequency—unless they receive reimbursement for the trip.[130] Yet, while alternative destination programs could result in significant healthcare cost reductions, these programs face their own set of financial obstacles. In many states, ambulances are reimbursed through specific grants from the state set aside for the purpose of keeping these programs afloat, but that model may not be scalable.[131] Likewise, many programs involving alternative destinations run through earmarked grants from the state for pilot programs available to select localities, and only a handful of states, such as Minnesota and Georgia, have extended Medicaid reimbursement. Although there are many ways in which jurisdictions could resolve these cost concerns, expanding reimbursement through federal programs may be an especially effective means of addressing the cost issue. Medicaid remains the most common payer type of all emergency department visits,[132] and private insurers often follow the lead of Medicare and Medicaid reimbursement policies.

CONCLUSION

For the five policies examined in this paper, there is no 'typical' statute. Each area exhibits a stunning variety of statutory permutations across a handful of key legislative lines. A protective custody procedure, for example, in one state may look wildly different from that of a neighboring one, and the complete package of protective custody, emergency holds, citation authority, Good Samaritan laws and ambulance regulations can result in a pre-arrest diversion and crisis response landscape that is fundamentally and critically different. At the same time, continued legislative attention in recent years that generally attempts to expand the reach of these policies means that they are only more likely to affect future pre-arrest diversion and crisis response strategies.

The depth of relevant research has generally not matched the complexity or popularity of these policy areas. For instance, while the mental health community has largely rallied behind the idea that jail is no place for the mentally ill, there is no similar consensus or research base on how to structure an emergency hold to facilitate productive outcomes. Likewise, research on Good Samaritan laws is rel-

127. Hilary Gates, "Medicare Announces Payment Model To Reimburse for On-Scene Treatment, Alternative Destinations," *EMSWorld*, Feb. 14, 2019. https://www.emsworld.com/article/1222205/medicare-announces-payment-model-reimburse-scene-treatment-alternative-destinations.

128. These policies may also need to include some form of liability protection to ensure that the transport of an individual to an alternative destination that is reasonable under the circumstances, but ultimately results in complications, does not subject the first responder in question to undue legal action, which could have the further effect of disincentivizing future alternative destination use.

129. Melody Glenn et al., "State Regulation of Community Paramedicine Programs: A National Analysis," *Prehospital Emergency Care* 22:2 (2018), p. 250. https://www.tandfonline.com/doi/10.1080/10903127.2017.1371260.

130. Similarly, one study surveyed the heads of community paramedicine programs across the country, and 86 percent agreed that funding or reimbursement was a primary obstacle. "Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)," p. 17. http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.

131. See "Final Report on the Community Paramedic Mobile Crisis Management Pilot Program: Report to the Joint Legislative Oversight Committee on Health and Human Services," North Carolina Dept. of Health and Human Services, Nov. 1, 2016. https://files.nc.gov/ncdhhs/SL%202015-241%20Section%2012F%208%20d%20Community%20Paramedicine.pdf; and Arthur Hsieh, "Without insurance changes, CP programs will be on life support," *EMS1*, March 17, 2015. https://www.ems1.com/community-paramedicine/articles/2137687-Without-insurance-changes-CP-programs-will-be-on-life-support.

132. Ruirui Sun et al., "Trends in Hospital Emergency Department Visits by Age and Payer, 2006–2015," Agency for Healthcare Research and Quality: Healthcare Cost and Utilization Project, March 2018, p. 1. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb238-Emergency-Department-Age-Payer-2006-2015.pdf.