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Crisis Urgent Care and Observation Facilities (Health Services -- Behavioral Health)

[LFB 2023-25 Budget Summary: Page 280, #1]

CURRENT LAW

All counties are required to have an emergency mental health service program, also known as crisis intervention service, to respond to individuals experiencing a crisis. Crisis intervention services involve the assessment, intervention, and stabilization of an individual experiencing a crisis stemming from a mental disorder. Services can be provided at any location, including in a person's home, a school, hospital, nursing home, or public place.

At a minimum, county emergency mental health programs must offer 24-hour crisis telephone service and 24-hour in-person service on an on-call basis. Telephone service must be staffed by mental health professionals or paraprofessionals or by trained mental health volunteers, backed up by mental health professionals. In order to receive reimbursement under the state's medical assistance (MA) program (for services provided to persons who are eligible under that program), an emergency mental health services program must have additional features, such as a mobile crisis team for on-site in person response, walk-in services, and short-term voluntary or involuntary hospital care when less restrictive alternatives are not sufficient to stabilize an individual experiencing a mental health crisis. All but seven counties (Bayfield, Douglas, Florence, Iron, Trempealeau, Vernon, and Washburn are the exceptions) have a crisis intervention service that meets MA certification criteria or participate in a multi-county certified program.

Chapter 51 of the statutes (State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act) establishes procedures for the involuntary emergency detention of persons who are deemed a threat to themselves or other because of mental illness. Under these provisions, a law enforcement officer may take a person into custody if the officer has cause to believe all of the following: (a) the person is mentally ill or drug dependent; (b) the person evidences a

substantial probability of physical harm to himself or herself or to others, including an inability to satisfy his or her basic needs due to mental illness or drug dependency; and (c) taking the person into custody is the least restrictive alternative appropriate to the person's needs.

Once a person is in custody, the county department of human services must conduct a crisis assessment, either in person, by telephone, or by telemedicine or video conferencing technology, to determine if the person meets the criteria for emergency detention. If, following this assessment, the county department agrees for the need for detention, the person must be transported to an approved treatment facility, if the facility agrees to take the individual, or to a state mental health institute. The Winnebago Mental Health Institute, in Oshkosh, must accept all individuals transported to that facility for emergency detention. DHS charges counties a daily rate and some service add-on fees to cover the cost of the care and treatment services provided at Winnebago. Some privately operated general or psychiatric hospitals and county-operated psychiatric hospitals also accept some individuals for emergency detention.

DISCUSSION POINTS

1. Under DHS administrative code, a "crisis" is defined as a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual. As defined in this rule and used in this context, a "mental disorder" includes psychiatric conditions, but also dementia and substance addiction.

2. In some cases, a behavioral health crisis may cause an individual to pose a threat to themselves or others. In these circumstances, law enforcement officers, mobile crisis teams, or both may be called upon to intervene. If the Chapter 51 statutory criteria of dangerousness are met, and the individual does not voluntarily submit to intervention, the individual may be taken into custody and transported to a treatment facility for emergency detention. If a court subsequently determines, during the period of emergency detention, that a person continues to meet criteria related to dangerousness (among others), it may order involuntary civil commitment for ongoing treatment, usually on an inpatient basis.

3. Only some behavioral health crises entail a threat of harm to the individual experiencing the crisis or a potential threat of harm to others. But even when not posing an imminent danger of physical harm, a crisis may lead to other serious consequences, such loss of employment or wages, substance abuse, a deterioration in physical health, family stress and dissolution, disruption to any ongoing education or training, criminal behavior, long-lasting impacts of crisis-related traumatic experiences on self and others, and overall loss of life satisfaction.

4. In recent years, both nationally and in Wisconsin, mental health practitioners, law enforcement agencies, and mental health consumer groups, have raised concerns regarding what they see as persistent problems in the state and county behavioral health crisis systems. Among these problems is an overuse of hospital emergency departments for behavioral health crisis, the significant resource drain posed by the current emergency detention process, and the use of criminal arrest and detention for minor offenses that stem from unaddressed behavioral health crisis episodes.

5. While these challenges affect the entire range of the crisis system services, the emergency detention process has been an area of particular concern in Wisconsin. In some emergency detention cases, a private or county hospital can take the individual for treatment. However, if such a hospital is not available, and the person is medically cleared for transport, the person must be transported to the Winnebago Mental Health Institute in Oshkosh. In addition to being a potentially difficult experience for the individual, the trip to Winnebago can impose a significant burden on law enforcement personnel, particularly if the person is transported from a great distance away.

6. Nationally, proposals to improve the behavioral crisis system have focused on developing a more robust spectrum of community-based crisis intervention services, in order to provide intervention services at varying levels, to match crisis episodes at varying levels of severity. The ultimate goal for having a full spectrum of services is to prevent crisis episodes from escalating to the point where disruptive and costly interventions, such as hospitalization or arrest, become necessary or are the only available options.

7. The National Action Alliance for Suicide Prevention is a coalition organization representing public and private entities involved in behavioral health systems in the United States. In 2016, with support of the federal Substance Abuse and Mental Health Services Administration (SAMSHA), the Alliance conducted a comprehensive review of state and local behavioral health crisis systems, including an examination of evidence on outcomes. Based on this review, the Alliance developed a set of recommendations for crisis system best practices, which has become known as the "Crisis Now" model.

8. In 2020, SAMSHA published a report entitled, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, which presents more detailed recommendations for the Crisis Now Model. According to SAMSHA's report, the Crisis Now model has three core crisis services: (a) a regional crisis call center, to engage individuals in crisis, perform risk assessment, and coordinate crisis care; (b) mobile crisis teams, to reach individuals wherever they are in the community; and (c) a crisis receiving and stabilization service, typically a facility used for observation and assessment in a non-hospital setting for a period of 24 hours or less. In addition to these core elements, the report discusses best practices for all core services and highlights the importance of robust collaboration between levels within the system, including with non-crisis behavioral health services.

9. The last of these core services, the crisis receiving and stabilization service, is intended to serve as a hub for in-person triage and observation for individuals experiencing a crisis. The Crisis Now model envisions that these facilities do all of the following:

- Accepts walk-ins or drop-offs by ambulance services, law enforcement officers, or mobile crisis units, and transfers from other healthcare facilities, without requiring the individual to receive prior medical clearance and without requiring the person making the drop-off to stay at the facility for processing.

- Operates under a "no wrong door" principle, meaning that it accepts all adults or youth experiencing a mental health and substance use crisis, and including a crisis episode related to dementia or intellectual disability.

- Accepts persons on a voluntary basis, but also for involuntary treatment, such as under Wisconsin's Chapter 51 emergency detention law.

- Provides an assessment and screening for conditions related to the crisis episode, as well as an assessment of physical health conditions.

- Provides medication management, therapeutic counseling, and monitoring for the condition or conditions underlying the crisis episode, with discharge or transfer to other care providers occurring within 24 hours of arrival.

- Is staffed and equipped to provide treatment for minor physical issues, and accepts responsibility for transferring a person to a hospital or other healthcare facility if that becomes necessary.

- Arranges for follow-up care, as necessary, either to a higher level of care, such as a residential crisis stabilization service or inpatient hospital, or to a lower level of care, such as community-based treatment on an outpatient basis, or supportive social services.

- Provides services in a "living-room" type of environment, rather than in an institutional setting to reduce stress.

10. Several other states have established crisis systems with crisis urgent care and observation facilities that are based on the Crisis Now model. Arizona, which is considered one of the first states to follow the model, contracts with regional behavioral health authorities (RHBAs) to establish the core elements of the system, including crisis urgent care and observation facilities. In state fiscal year 2023, the state budgeted $16.4 million, primarily from the general fund, to support crisis system services delivered by three RHBAs. This funding is combined with other funds, including from the state's Medicaid program, to support behavioral services delivered by RHBAs under a capitated managed care model. Other states that have been recognized for their crisis systems based on the Crisis Now model are Colorado, Georgia, Utah, and Virginia.

11. The crisis receiving and stabilization service, as outlined in the Crisis Now model, can sometimes be confused with a crisis stabilization facility, but they are distinct facility types and serve different functions within the behavioral health crisis system. As the crisis stabilization service is defined and licensed in Wisconsin, the facility does not accept involuntary patients, cannot provide medical clearance or treatment for physical health issues, and does not serve as a triage and referral site for other levels of care. Whereas a crisis receiving and stabilization service is intended for short-term assessment, management, and referral, with stays lasting less than a 24-hour period, a crisis stabilization service offers a short-term residential service, typically lasting three to seven days. Because of these differences, a crisis receiving and stabilization service has different staffing requirements, as well as space and equipment requirements, than a crisis stabilization service.

12. In Wisconsin, crisis stabilization facilities are available in some counties, and are typically licensed as a community-based residential facility, an adult family home, or a youth crisis stabilization facility. DHS maintains that it currently lacks the statutory authority to establish non-hospital facility license for a crisis receiving and stabilization service that conforms to the Crisis Now

model. The Department indicates that there are two county human services agencies--North Central Healthcare, the human services agency for Marathon, Langlade, and Lincoln counties, and Milwaukee County--that operate a crisis urgent care facility that follow the Crisis Now model, but that in both these cases, the facilities operate within, or as a satellite of, a licensed hospital. Being licensed as a hospital, the Department maintains, complicates these facilities' ability to bill Medicaid or other insurance for crisis intervention services, and thus does not conform to the Crisis Now model.

13. To address this licensing issue, AB 43/SB 70 would create a new behavioral health service, with a facility licensing requirement, designated as a crisis urgent care and observation facility. A summary of the proposed statutory provisions is shown in the appendix to this paper.

14. The need for and timing of behavioral health crisis intervention services for any individual is inherently unpredictable. On a population level, the total need for crisis services may be somewhat more predictable, but not sufficiently enough to closely match the availability of services to the demand for services. Thus, as with other unscheduled public services like emergency medical or fire department services, the service must be on standby, even when it is not being used directly. This aspect of the service means that the cost of providing the service cannot generally be recovered from patient charges alone, since the reimbursement payments (from Medicaid, Medicare, or commercial insurance) may cover the marginal cost of providing the service, but not generally the fixed standby costs. Furthermore, not all individuals who use crisis intervention services have health insurance, and commercial insurance policies may not fully cover crisis services. For these reasons, a behavioral crisis system that follows the Crisis Now model cannot usually be supported through patient charges alone. The states or localities that have established a crisis system with comprehensive coverage have required supplemental public funding to do so, for both up-front costs and stand-by costs.

15. In addition to establishing the crisis urgent care and stabilization facility type, the bill would provide $9,955,600 GPR in 2024-25 to make grants to support two regional facilities, as well as 1.0 GPR position (and associated funding of $64,700 in 2023-24 and $82,900 in 2024-25) to administer the program. The position would help develop and implement the administrative rules for the facilities, develop grant materials, monitor contracts, and work with counties, law enforcement, and providers to integrate the facilities with the crisis system.

16. The amount of funding for grants was based on an estimate of 80% of the annual operations costs for two facilities with a capacity for 16 individuals, with staffing that includes psychiatrists, psychiatric nurse practitioners, registered nurses, social workers, and medical services assistants. The calculations assume that the other 20% of cost could be supported from billing Medicaid or other insurance. The Administration indicates that over time the facilities may be able to generate a higher portion of their operating costs through billing, and in this event, the funds could be used to support additional regional crisis urgent care and stabilization facilities.

17. The proposal for establishing a crisis urgent care observation facility is intended to adopt one part of the Crisis Now model in Wisconsin. Some interested parties have indicated support for this concept, although they have also expressed some ongoing concerns regarding the proposal included in AB 43/SB 70, including whether such a facility will be viable in all parts of the state, and whether potential providers (which could be counties) would be willing to take the financial risks

needed to establish a facility. In addition, the manner and amount of reimbursement under the medical assistance program are yet to be resolved. DHS indicates that, if approved, it would seek input from counties and potential facility operators to work through issues involved in establishing facilities and reimbursing for services.

18. The 2021-23 budget act set aside $10,000,000 GPR in the Committee's program supplements appropriation for crisis facilities and services, an amount that is similar to the proposed funding under the bill. In submitting its request, the Department noted that it lacked the statutory authority to establish a license for a crisis urgent care and observation facility, so the funds could not be used for that purpose. Instead, the Department proposed that the funds would be used for crisis system improvements that could be implemented under the current law framework.

19. If the Act 58 funding is not released by the Committee by the end of the 2021-23 biennium, it will lapse to the general fund. The Committee could determine that any funding provided for crisis systems improvement could be better utilized as part of a crisis urgent care and observation facility, based on the Crisis Now model. In this case, the Committee could adopt the statutory provisions necessary for the licensing of such a facility and the proposed funding for making grants to support the facility and to administer the program. [Alternative A1 and B1, respectively]

20. As noted, if the statutory changes for the crisis urgent care and observation facility are approved, there would still be some issues to be resolved regarding financing of the operations. One alternative for consideration would be to provide less funding for making grants than AB 43/SB 70 would. Starting with a smaller program may allow the Department and the Legislature to gauge the interest among counties or other providers in operating such a facility before a larger commitment is made to supporting more regional facilities. Using the same assumptions DHS used to develop the funding proposal in the bill, a grant to support one facility would be $4,977,800 GPR in 2024-25. [Alternative B2]

21. Both Alternatives B1 and B2, relating to the creation of a grant program, would include 1.0 GPR position to administer the program. This level of administrative support is reasonably consistent with other grant programs of similar scale and complexity.

22. The Committee could determine that any crisis urgent care and observation facility should be operated without state support. Some counties may determine that the benefits of such a facility, in terms of savings from avoiding emergency detentions and civil commitment and other acute services, may be sufficient to offset any unreimbursed costs for operating such a facility. As an example, Dane County is in the process of establishing a crisis urgent care and observation facility based on this model, believing that there will be some offsetting costs to the county, as well as other benefits to county residents. Other larger counties may also determine that the potential benefits are sufficient to outweigh the operating costs. In this case, the Committee could approve the creation of the facility, but without establishing a state grant program. [Alternative A1 and B3]

23. The Committee could also determine that additional work with interested parties is needed before finalizing the statutory provisions creating the crisis urgent care and observation facility. In this case, a decision could be made to not include the proposed statutory changes and instead consider the issue as a standalone bill. [Alternative A2] This alternative could be selected even if a decision is made to establish a grant program under Alternatives B1 or B2.

ALTERNATIVES

A. Statutory Provisions for Establishing a Crisis Urgent Care and Observation Facility

1. Approve the proposal in AB 43/SB 70 to establish a crisis urgent care and observation facility type by statute and authorize DHS to promulgate administrative rules with standards for such a facility, as outlined in the appendix.

2. Take no action.

B. Crisis Urgent Care and Observation Facility Grant Funding

1. Approve the proposal included in AB 43/SB 70 to provide $9,955,600 GPR in 2024-25 to make grants to support two regional facilities, as well as 1.0 GPR position, and associated funding of $64,700 in 2023-24 and $82,900 in 2024-25, to administer the program.

ALT B1	Change to Base	
	Funding	Positions
GPR	$10,103,200	1.00

2. Provide $4,977,800 GPR in 2024-25 for a grant program for a crisis urgent care and observation facility and 1.0 position, with associated funding of $64,700 in 2023-24 and $82,900 in 2024-25, to administer the program.

ALT B2	Change to Base	
	Funding	Positions
GPR	$5,125,400	1.00

3. Take no action.

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Appendix

APPENDIX

Establishing a Crisis Urgent Care and Observation Facility

Summary of AB 43/SB 70 Provisions

Specify that a crisis urgent care and observation facility shall do all of the following: (a) accept referrals for crisis services for both youths and adults, including involuntary patients under emergency detention, voluntary patients, walk-ins, and individuals brought by law enforcement, emergency medical responders, and other emergency medical services practitioners; (b) abstain from having a requirement for medical clearance before admission assessment; (c) provide assessments for physical health, substance use disorder, and mental health; (d) provide screens for suicide and violence risk; (e) provide medication management and therapeutic counseling; (f) provide coordination of services for basic needs; (g) have adequate staffing 24 hours a day, seven days a week, with a multidisciplinary team including, as needed, psychiatrists or psychiatric nurse practitioners, nurses, licensed clinicians capable of completing assessments and providing necessary treatment, peers with lived experience, and other appropriate staff; and (h) allow for voluntary and involuntary treatment of individuals in crisis as a means to avoid unnecessary placement of those individuals in hospital inpatient beds and allow for an effective conversion to voluntary stabilization when warranted in the same setting.

Specify that a crisis urgent care and observation facility may accept individuals for emergency detention under Chapter 51 of the statutes if the facility agrees to accept the individual, but specify that a county crisis assessment is required prior to acceptance of an individual for purposes of emergency detention at a crisis urgent care and observation facility. Specify that medical clearance is not required before admission, but that the facility must provide necessary medical services on site.

Specify that a crisis urgent care and observation facility may accept individuals for voluntary stabilization, observation, and treatment, including for assessments for mental health or substance use disorder, screening for suicide and violence risk, and medication management and therapeutic counseling.

Specify that no person may operate a crisis urgent care and observation facility without a certification for such a facility issued by the Department. Require the Department to establish a certification process for crisis urgent care and observation facilities, and specify that the Department may establish, by rule, criteria for the certification of such a facility. Specify that the Department may limit the number of certifications it grants to operate crisis urgent care and observation facilities. Require DHS to establish, by rule, a process for crisis urgent care and observation facilities to apply for provider certification under the Medical Assistance program.

Specify that a crisis urgent care and observation facility is not considered a hospital under statutory provisions pertaining to hospital regulation and specify that a crisis urgent care and observation facility is not subject to facility regulation applicable to hospitals, unless otherwise required due to the facility's licensure or certification for other services or purposes.

Specify that services provided by a crisis urgent care and observation facility that is certified by the Department are considered crisis intervention services for the purposes of eligibility for reimbursement under the Medical Assistance program. Require DHS to request any necessary federal approval required to provide reimbursement to crisis urgent care and observation facilities for crisis intervention services. Require DHS to provide reimbursement for such services if federal approval is granted or no federal approval is required. Specify that if federal approval is necessary but is not granted, the Department may not provide reimbursement for crisis intervention services provided by crisis urgent care and observation facilities.

For these purposes, define "crisis" as a situation caused by an individual's apparent mental or substance use disorder that results in a high level of stress or anxiety for the individual, persons providing care for the individual, or the public and that is not resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual. Define "crisis urgent care and observation facility" as a treatment facility that admits an individual to prevent, de-escalate, or treat the individual's mental health or substance use disorder and includes the necessary structure and staff to support the individual's needs relating to the mental health or substance use disorder.

Authorize the Department to promulgate rules to implement provisions related to crisis urgent care and observation facilities, including requirements for admitting and holding individuals for the purposes of emergency detention. Authorize the Department to promulgate an emergency rule that may remain in effect for not more than 24 months, without meeting prerequisites that otherwise apply to emergency rulemaking authority.