PLANNING STEP 1

Criterion 1: Comprehensive Community Based Mental Health Systems

The Department of Public Health and Human Services (DPHHS) under the Executive Branch of Montana (MT) State Government, administers a wide spectrum of programs and projects including public assistance, Medicaid, licensing, foster care and adoption, long-term care, aging services, substance use disorder (SUD) programs, mental health services, vocational rehabilitation, disability services, child support enforcement activities, and public health functions (such as communicable disease control and preservation of public health through chronic disease prevention). The Department’s mission states: Improving and protecting the health, well-being, and self-reliance of all Montanans. These Branches provide oversight to following Divisions.

Economic Security Services Branch (provides direct supervision over:
- Human and Community Services Division (HCSD);
- Child Support Enforcement Division (CSED);
- Child and Family Services Division (CFSD); and
- Disability Employment and Transitions Division (DETD).

Medicaid and Health Services Branch provides direct supervision over:
- Senior and Long-Term Care Division (SLTC);
- Developmental Services Division (DSD);
- Addictive and Mental Disorders Division (AMDD); and
- Health Resources Division (HRD).

Operations Services Branch provides direct supervision over:
- Business and Financial Services Division (BFSD);
- Quality Assurance Division (QAD); and
- Technology Services Division (TSD).

DPHHS Divisions that provide assistance, services, and support outside of youth and adult mental health services, and a brief description of their scope of authority, are listed below:

The HCSD provides cash assistance, employment training, food stamps, Medicaid, child care, meal reimbursement, nutrition training, energy assistance, weatherization, and other services to help families move out of poverty and toward self-support.

The CSED provides State and Federally mandated child support enforcement services. These include locating absent parents, establishing paternity, establishing financial and medical support orders, enforcing current and past-due child support, offering medical and spousal support, and modifying child support orders.

The CFSD provides State and Federally mandated protective services to youth who have been or at substantial risk to be abused, neglected, or abandoned. This includes receiving and investigating reports of child abuse and neglect, working to prevent domestic violence, helping families to stay together or reunite, and finding placements in foster or adoptive homes. Many youth served by this Division receive public mental health services.

The DETD is charged to advance the employment, independence, and transitions of Montanans with disabilities. DETD offers a variety of services, ranging from employment planning to transportation coordination. Disability Employment and Transitions also works with a variety of other agencies to reduce barriers for people with disabilities so that all Montanans can be free to fulfill their potential and contribute to their communities.
The SLTC division manages a wide variety of programs and services such as providing information, education, and assistance; planning, developing and providing for quality long-term care services; and operating within a cost–effective service delivery system.

The DSD offers a wide range of services to fulfill its mission of facilitating efficient delivery of effective services to adults and children with developmental disabilities and children with serious emotional disorder (SED).

HRD administers Medicaid primary care services. The purpose of the division is to improve and protect the health and safety of Montanans. The division reimburses private and public providers for a wide range of preventive, primary, and acute care services. Major service providers include: physicians, public health departments, clinics, hospitals, dentists, pharmacies, durable medical equipment, and mental health providers.

Operations Services Branch provides leadership for the department’s implementation and operations of programs and services.

On the following page is a copy of the DPHHS Organizational Chart.
MT’s community-based mental health services are provided by a variety of local agencies including licensed Mental Health Centers, independent private practitioners, Federally Qualified Health Centers (FQHC), and short-term psychiatric inpatient units in community hospitals. The psychiatric inpatient units are located in Kalispell, Missoula, Billings, Helena, Glendive, and Great Falls. MT currently has 13 licensed Mental Health Centers that can provide community-based services in 55 of 56 counties, with the use of satellite offices, and approximately 24,573 individuals determined eligible for Medicaid or State supported mental health services. Mental Health Center locations may be reviewed on the Mental Health Center map below.

The Mental Health Services Bureau (MHSB) provides evaluation and technical support to the local and regional planning groups, regional Service Area Authorities (SAA), and Local Advisory Councils (LAC). SAAs are statutorily defined for the purpose of collaboration with the Department for the planning and oversight of mental health services within a service area. LACs are a coalition of individuals within communities interested in planning, evaluating, and strengthening their local community mental health services. All local planning groups are encouraged to ensure activities are conducted through a broad and inclusive representation of the community mental health system, including community mental health providers, advocates, law enforcement, judicial system, hospitals, and other medical service providers. LACs are the foundation for recommendations to the SAA, MHSB, and Mental Health Oversight Advisory Council (MHOAC), on program issues affecting local communities. The MHSB also facilitates and provides administrative functions for the MHOAC.

MT’s Adult Mental Health Communications System

- Consumer
- Family Members
- Providers

SAA
- LAC Rep
- LAC Rep
- Consumers
- Family Members
- Providers
- State Officals

LAC
- Rep
- Family Members
- Providers
- Consumers

MHOAC
- MT PATH Program
- Children’s MH
- Adult MH
- Substance Use

MHBG
MHSB field staff, support the development and evaluation of community based services throughout the State. The Community Program Officers (CPOs) foster and support collaborative relationships between the MHSB and community stakeholders.

Community Liaison Officers (CLOs) provide reintegration support services to individuals who have been discharged from the MSH and to individuals who have received crisis stabilization services. These duties require that the CLOs have expert knowledge of community and natural supports and how to effectively access them in the transition process; ability to facilitate individuals’ development of personal goals; and skill to facilitate consumer involvement in community activities and supports that lead to independent living, reduced hospitalization, and recovery.
Location of Mental Health Centers and Telemedicine Network Sites
Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems.

AMDD, through the MHSB, is responsible for the development and management of the community adult mental health system (age 18 and over). AMDD also provides services through 3 inpatient facilities; the Montana State Hospital (MSH) in Warm Springs, Montana Chemical Dependency Center (MCDC) in Butte, and MT Mental Health Nursing Care Center (MMHNCC) in Lewistown. The AMDD is responsible for the development and oversight of the State’s system for delivering and reimbursing publicly funded Federal, State, and special revenues adult mental health services. The MHSB ensures the availability and efficient delivery of appropriate and effective services. The MHSB also provides extensive monitoring of program implementation, operation, analysis, and reporting of program operations, costs, and outcomes. Individuals eligible for services include adult Medicaid members and other low-income Montanans with severe disabling mental illness.

In addition, AMDD assess the need for SUD prevention, treatment, and recovery throughout MT through the Chemical Dependency Bureau (CDB). Those services are available through contracts with 21 State-approved programs that practice a co-occurring approach to treatment. The bureau reimburses for a full range of outpatient and inpatient services. The CDB also organizes and funds activities designed to prevent the use/abuse of alcohol, tobacco, and other drugs youth and adults. Individuals, not Medicaid eligible, with substance abuse disorders who have family incomes below 200 percent of the Federal poverty level are eligible for public funded treatment services. In addition, the Medicaid program funds outpatient and residential SUD treatment for adults and youth who are Medicaid eligible.

The CMHB, located in the DSD, is the State’s children’s mental health Medicaid agency. The CMHB develops and manages Medicaid mental health services for individuals under the age of 18 who have been diagnosed with a SED. For additional information go to Criterion 3: Children’s Services. (Page 10) AMDD and CMHB work together to address the critical need for providing care to transitional age youth by improving the infrastructure for and access to treatment and recovery services. Efforts include collaboration with parents, transitional age youth, and other State agencies.

For a summary of the programs, services, trainings, and facilities (Attachment A-MT Community Behavioral Health Table).

Describe how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

American Indian

In MT, the provider for health care for American Indians is both the Federal government via Indian Health Services (IHS), Tribal Health Departments, Urban Indian Health Centers, and through Medicaid. On the 7 Federally recognized reservations, there are 3 hospitals that are classified as IHS as well as 2 tribally owned and operated health programs. Despite the availability of these health services, nearly 2/3 of American Indians in MT live in medically underserved counties and frequently report barriers to care access. The 2011 Behavioral Risk Factor Surveillance System (BRFSS) survey reported American Indian residents said they did not have a person they regarded as their usual health care provider.

The 2016 Governor’s Council on Health Care Innovation and Reform (Attachment B, MT Health Care and Innovation Plan) found, “The age-adjusted mortality rate for non-Indian residents of MT was substantially lower than for American Indian residents: 742.6 per 100,000 compared to 1184.6 per 100,000. In addition, the mortality rates for many individual causes of death were lower for non-Indian residents than for American Indian residents.” According to the American Journal of Public Health, “…suicide is the second leading cause of death among Native adolescents and young adults, at a rate of 2.5 times higher than the national average rate. Rates for death by suicide among non-Native populations
peak in older adulthood, whereas rates of death of suicide among Native populations peak during adolescence and young adulthood.” This sobering fact is supported in MT’s 2016 Suicide Mortality Review Team Report which found that, “Suicide deaths by American Indians ages 11 to 24 occur at the rate of 42.82 per 100,000 deaths. Compared to the statewide suicide rate of 8.01 per 100,000 for ages 11 to 24, the American Indian rate is more than 5 times as high.”

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>% of Total Population</th>
<th>% of Total Population of Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td>6.6%</td>
<td>12%</td>
</tr>
<tr>
<td>Asian</td>
<td>Less than 1%</td>
<td>Less than 1%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>Less than 1%</td>
<td>1%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>Less than 1%</td>
<td>Less than 1%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>3.6%</td>
<td>1%</td>
</tr>
<tr>
<td>White</td>
<td>89.2%</td>
<td>78%</td>
</tr>
<tr>
<td>More Than 1 Race Reported</td>
<td>2.7%</td>
<td>2%</td>
</tr>
</tbody>
</table>

To address this issue IHS, Tribal Health Departments, Urban Indian Health Centers, DPHHS, and the University of MT’s National Native Children’s Trauma Center have joined forces to develop the MT Native Youth Suicide Reduction Strategic Plan. (Attachment C, MT Native Youth Suicide Reduction Strategic Plan). The goal of the plan is to, “…create an environment where zero suicides becomes the norm in tribal and urban Indian communities.”

**Youth with SED and their Families**
Go to section entitled Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness. (Page 39)

**Older Adults**
Go to Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults (Page 16)

**Individuals with Serious Mental Illness (SMI) or SED in the rural and homeless populations**
Go to Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults (Page 16)

**Lesbian, Gay, Bi-Sexual, Transgender (LGBT)**

Another population in MT that is at high risk for suicide are those of the LGBT community. National studies have shown that 15% of youth who attempt suicide also report same-sex attraction or relationships. While the number of LGBT individuals living in MT is difficult to determine, according to the MT Strategic Suicide Prevention Plan 2017, “Suicide prevention and intervention efforts should consider the role that victimization plays in the everyday lives of all youths and its potential effects on suicidality. As identified above, among primary youth suicide risk factors, high levels of depression and alcohol abuse are reported by same-sex orientation.” To this end the plan provides, “…directions for the prevention, intervention, postvention, and coordination among providers.” (Attachment D, MT Strategic Suicide Prevention Plan)

**Criterion 2: Mental Health System Data Epidemiology**
Substance Abuse and Mental Health Services Administration’s (SAMHSA) Drug and Alcohol Services Information System in 2016, reflects MT provided services for 49,935 adults with SMI and youth with SED, a penetration rate of 48 percent. This is an increase from 2015 by 7 percent.
The increase in the utilization rate of mental health services is attributed to the raise in numbers of those individuals enrolled in the MT Medicaid Program. In a DPHHS Report to the 2017 MT Legislature, it was reported that, “Medicaid reimbursed over $1 billion dollars in SFY 2015. Most of these funds were spent in MT and went to private providers. Not only do these funds contribute to the MT economy, Medicaid funding helps assure access to services in rural and frontier areas of our State. Medicaid is the primary (and often the only) payment source for long term care services for the elderly and people with an intellectual disability or a SMI.”
AMDD’s goal is to provide access to mental health services equitable to the needs of adults experiencing severe disabling mental illness (SDMI) and youth experiencing SED.

**Criterion 3: Children’s Services**

**Overview of CMHB**

CMHB is part of the DSD. The DSD assists Montanans with disabilities and youth with SED to live, work, and participate in their communities. The Division contracts for institutional care, residential services, home based services to youth and families, case management, and a variety of employment related services.

The CMHB supports MT youth and families in accessing effective mental health care to meet their needs through management and funding mental health services for 19,782 youth enrolled in MT Medicaid in SFY 2016. CMHB provides leadership through the provision of quality reviews, which may include retrospective reviews, service reviews, and quality audit reviews, CMHB promotes both efficiency and quality mental health care for youth.

The CMHB is organized into a central office with staff to include management, program, clinical, and administrative staff. CMHB also has Regional Offices in Billings and Missoula. The central office provides statewide utilization management of mental health services for youth under age 18 (or until 19 if still in secondary school), along with policy development, administrative rule writing, training and technical assistance for providers, technical support for provider payment and processing, and Federal reporting and compliance.

Regional staff assists youth and families to access resources, approve youth enrollment into non-Medicaid services, and monitor provider compliance with State and Federal regulations. Regional staff also helps develop and support community-based alternatives for youth with SED at risk of placement out of their communities and provides oversight of discharge planning for youth with SED returning from Psychiatric Residential Treatment Facility (PRTF).

**Children’s System of Care (SOC) Planning Committee**

The [Children’s SOC Planning Committee](#) was established by statute in 1993 ([52-2-301, 52-2-303,52-2-304 MCA]) to develop an integrated service system for youth under age 18 who are SED, at risk for placement in an out-of-home setting, and needing the assistance of more than 1 State agency. The statute was updated in 2001 to further describe a SOC and to define the duties of the planning committee. The [Children’s SOC Planning Committee](#) is made up of approximately 30 members who represent family members of youth, Native Americans, advocacy groups, and mental health providers that serve youth and community members. The Director of DPHHS is responsible for appointing the members. The work of CMHB with the SOC Planning Committee is guided by the following values:

- Family and youth participation at all levels of the youth’s SOC from policy planning to individual care planning;
- Cultural sensitivity in service design and delivery;
- A strengths-based focus on the family and youth as drivers of treatment and recovery;
- Respectful partnership with communities, including the tribes, to design and develop the SOC;
- Partnership with providers to increase use of evidenced-based and promising practices to serve youth with SED and their families; and
- An integrated focus on both mental health and chemical dependency treatment needs of youth with co-occurring disorders.
**School and Community Services for Youth**

Private providers (psychiatrists, psychologists, and mid-level practitioners) also offer mental health services for Medicaid and Healthy MT Kids (HMK/CHIP) eligible youth. Billings Clinic Behavioral Health psychiatrists assist with provision of psychiatric consultation for youth in rural eastern MT. An extensive telemedicine network reduces some of the necessity for families to travel to Billings for medication management for the youth.

For students with SED, Comprehensive School and Community Treatment (CSCT) programs in the schools provide mental health support in classrooms, 1:1 behavioral aides and individual, group and family therapy. CSCT is offered in many rural and reservation schools as well as in more populated communities. Youth do not have to qualify for special education services to receive CSCT. CSCT programs can bill Medicaid, private insurance, or offer a private pay sliding fee scale option.
<table>
<thead>
<tr>
<th>Services</th>
<th>Description</th>
<th>Services Setting</th>
<th>Prevention</th>
<th>Early ID</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Hospital Service (AIHS)</td>
<td>An accredited psychiatric facility devoted to inpatient care for individuals under 21</td>
<td>Facility</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>PRTF</td>
<td>An accredited facility whose primary purpose is the provision of providing residential psychiatric care for individuals under 21</td>
<td>Facility</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility Assessment Service (PRTF-AS)</td>
<td>Assessment services provided by a PRFT that is short-term (14 days or less) and designed to service youth with multiple diagnoses who are difficult to place</td>
<td>Facility</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Partial Hospital Services (PHP)</td>
<td>A time limited treatment program that consists of intensive therapy, coordinated, structured clinic services to youth with an SED</td>
<td>Facility</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Group Home (TGH)</td>
<td>Behavioral intervention and life skills development in a structured group home environment</td>
<td>Community</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Support Services (HSS)</td>
<td>In-home family support services for youth with SED exhibiting symptoms that are of a persistent nature</td>
<td>Home</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Therapeutic Foster Care (TFC)</td>
<td>In-home therapeutic and family support services for youth living in a licensed therapeutic foster home environment</td>
<td>Group home</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Foster Care Permanency (TFCP)</td>
<td>An intensive level of treatment for youth in a permanent therapeutic foster family placement</td>
<td>Group Home</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>CSCT</td>
<td>A comprehensive planned course of community mental health outpatient treatment that includes therapeutic interventions and supportive services provided in a public school</td>
<td>School and Community</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DayTx</td>
<td>Mental health services provided in a specialized classroom setting that is not co-located in a public school</td>
<td>School</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapy (OP)</td>
<td>Therapy services which diagnosis, assessment, psychotherapy, and related services are provided by a licensed mental health professional</td>
<td>Community</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>TCM</td>
<td>The process of planning and coordinating care and services to meet individual needs of a youth</td>
<td>Community, School, and Group Home</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Therapeutic Home Visit (THV)</td>
<td>To assess the ability of a youth to successfully transition to a less restrictive level of care</td>
<td>Community and Group Home</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Services</td>
<td>Description</td>
<td>Service Setting</td>
<td>Prevention</td>
<td>Early ID</td>
<td>Treatment</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------</td>
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<td>-----------</td>
</tr>
<tr>
<td>CBPRS</td>
<td>Additional 1:1, face to face, intensive short-term behavior management, and stabilization services</td>
<td>Group Home, Community and School</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Extraordinary Needs Aide Service (ENA)</td>
<td>1:1 staffing for youths in TGHs that cannot be managed by normal staff requirements</td>
<td>Group Home</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
## MEDICAID MENTAL HEALTH YOUTH
### SFY 2016 To-Date Expenditures by Provider Type based on Dates of Service

<table>
<thead>
<tr>
<th>Service Expenditure</th>
<th># Served</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Comprehensive School &amp; Community Treatment (CSCT)</td>
<td>5,105</td>
<td>$33,326,140</td>
</tr>
<tr>
<td>* Psychiatric Res Treatment Fac (PT38)</td>
<td>553</td>
<td>$21,049,278</td>
</tr>
<tr>
<td>* Therapeutic Group Home (PT61)</td>
<td>712</td>
<td>$20,349,958</td>
</tr>
<tr>
<td>* Home Support Service / Therap Foster Care (PT64)</td>
<td>1,679</td>
<td>$11,093,351</td>
</tr>
<tr>
<td>* Case Management- Mental Health (PT60)</td>
<td>4,588</td>
<td>$10,092,971</td>
</tr>
<tr>
<td>* Licensed Professional Counselor (PT58)</td>
<td>7,619</td>
<td>$7,208,788</td>
</tr>
<tr>
<td>* Mental Health Center (PT59)</td>
<td>2,391</td>
<td>$6,735,626</td>
</tr>
<tr>
<td>* Hospital - Inpatient (PT01)</td>
<td>756</td>
<td>$5,625,195</td>
</tr>
<tr>
<td>* Social Worker (PT42)</td>
<td>4,404</td>
<td>$3,824,345</td>
</tr>
<tr>
<td>* Direct Care Wage (CMHB) - Not a Service Type</td>
<td></td>
<td>$2,726,456</td>
</tr>
<tr>
<td>* Psychiatrist (PT65)</td>
<td>3,004</td>
<td>$2,207,691</td>
</tr>
<tr>
<td>* Hospital - Outpatient (PT02)</td>
<td>3,293</td>
<td>$2,027,068</td>
</tr>
<tr>
<td>* Physician (PT27)</td>
<td>6,187</td>
<td>$1,725,967</td>
</tr>
<tr>
<td>* Mid-Level Practitioner (PT44)</td>
<td>3,101</td>
<td>$1,409,796</td>
</tr>
<tr>
<td>* Federally Qual Health Center (PT56)</td>
<td>1,203</td>
<td>$900,515</td>
</tr>
<tr>
<td>* Psychologist (PT17)</td>
<td>1,309</td>
<td>$746,277</td>
</tr>
<tr>
<td>* Laboratory (PT40)</td>
<td>500</td>
<td>$427,523</td>
</tr>
<tr>
<td>* Rural Health Clinic (PT55)</td>
<td>962</td>
<td>$342,886</td>
</tr>
<tr>
<td>* Critical Access Hospital (PT74)</td>
<td>339</td>
<td>$333,665</td>
</tr>
<tr>
<td>* Respite (PT59)</td>
<td>290</td>
<td>$154,437</td>
</tr>
<tr>
<td>* Home &amp; Comm Based Services (PT28)</td>
<td>7</td>
<td>$63,221</td>
</tr>
<tr>
<td>* Indep Diag Testing Facility (PT72)</td>
<td>2</td>
<td>$1,344</td>
</tr>
</tbody>
</table>

**Total Children’s Medicaid Mental Health and CSCT**  
19,783  $132,372,499  100%

† Expenditures through December 1, 2016 based on Date of Service. Includes CHIP funded HMK+ Medicaid Expansion.
HMK/CHIP

HMK/CHIP is a low cost health insurance plan sponsored by DPHHS for MT youth up to age 19. HMK offers medical, dental, vision, prescription drug benefits, and mental health services. Mental health services include:

- Group, individual, and family therapy;
- Outpatient mental health assessments;
- AIHS;
- Psychological testing;
- Therapeutic youth group home (with prior approval); and
- Psychiatric residential treatment.

Youth determined to have a SED are eligible for additional mental health services:

- Therapeutic family care (90 days per benefit year);
- Day treatment (120 hours per benefit year);
- Respite care (144 hours per benefit year); and
- Community based psychiatric rehabilitation services (CBPRS) (120 hours per benefit year).

### Children's Mental Health Bureau Medicaid Services

<table>
<thead>
<tr>
<th>Children's Mental Health (CMH)</th>
<th>SFY2016 Clients</th>
<th>SFY2016 Expenditures</th>
<th>Average Per Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMH Medicaid Services</td>
<td>16,681</td>
<td>$93,860,786</td>
<td>$5,627</td>
</tr>
<tr>
<td>CMH Medicaid Comprehensive School &amp; Community Treatment (CSCT)</td>
<td>4,833</td>
<td>$30,751,401</td>
<td>$6,363</td>
</tr>
<tr>
<td>- Subtotal CMH Medicaid Client Services</td>
<td>18,559</td>
<td>$124,612,187</td>
<td>$6,714</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children's Mental Health Healthy MT Kids Plus (HMK+) Expansion**</th>
<th>SFY2016 Clients</th>
<th>SFY2016 Expenditures</th>
<th>Average Per Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMK+ Expansion (CHIP funded through HRD)</td>
<td>1,916</td>
<td>$5,185,573</td>
<td>$2,706</td>
</tr>
<tr>
<td>HMK+ Expansion CSCT (funded through HRD)</td>
<td>550</td>
<td>$2,574,739</td>
<td>$4,681</td>
</tr>
<tr>
<td>- Subtotal HMK+ Expansion Client Mental Health Services</td>
<td>2,121</td>
<td>$7,760,312</td>
<td>$3,659</td>
</tr>
</tbody>
</table>

| Mental Health Unique Clients Served / Total Expenditures | 19,783 | $132,372,499 | $6,691 |
Juvenile Justice

The Regional staff work as the liaisons to the Juvenile Justice system to ensure efforts are not only collaborative, but smooth when transitioning a youth in need of SED treatment from the Juvenile Justice system to a more appropriate setting.

Substance Abuse and Co-Occurring

AMDD maintains contracts with chemical dependency programs across the State for State-funded SUD treatment. In addition, CMHB manages a SAMHSA grant, Transitioning Youth at a Healthy Age, which addresses the critical need for providing evidence-based care to adolescents and transitional age youth with SUD and co-occurring disorders by improving the infrastructure for and access to treatment and recovery services.

Additionally, through a pilot project funded by a SAMHSA grant, CMHB was able to operationalize Integrated Co-occurring Treatment (ICT), which is the model developed by the Center for Innovative Practices at Case Western Reserve University, to treat youth with co-occurring SED SUD. Services are provided in the home or community where the youth lives, with the goal of safely maintaining the youth in the least restrictive and most normative environment. ICT provides a family driven, comprehensive mix of integrated services designed to meet the SED and SUD needs of the youth.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Rural Populations

The extent to which this mental health system serves MT’s extensive geographic area is impressive. The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

Because of the frontier nature of MT, our entire mental health service plan addresses the manner in which mental health services will be provided to individuals residing in rural/frontier areas. “Frontier” designation is determined through a weighted matrix of population density, distance in miles to a service/market center, and travel time in minutes. Over 800 of the country's 3190 counties have been


**Continue of Rural Populations**

designated as frontier by the Frontier Education Center in consultation with State Offices of Rural Health. Most frontier land is located in Alaska, the Great Plains, and the West. MT ranks number 3 out of 19 States that account for about 95 percent of the land designated as frontier. By comparison, MT ranks 6th in Largest Frontier Population and, as noted above, third in Largest Frontier Area (National Center for Frontier Communities).

Concentrating services in larger areas may be the most efficient strategy for service delivery, however, MT has maintained an effort to provide individuals a choice of mental health services in every county in the State primarily through the Mental Health Centers and telemedicine. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, supportive therapy, and case management including TCM.

**Homeless Populations**

The Projects for Assistance in Transition from Homelessness (PATH) programs supports SAMHSA’s Strategic Initiates; specifically, Recovery Support. Three major Mental Health Centers concentrate service delivery in the areas of: outreach, inreach, screening and diagnostic treatment, community mental health, case management, referral for primary health services, job training, education, and relevant housing services. Enrolled individuals will all be provided the opportunity to transition to Mental Health Center services as soon as eligible and the MT PATH Program can ensure service stability for the individual. The MT PATH Program is critical to provide the outreach necessary for those experiencing severe and persistent mental illness and homelessness to access the mainstream public mental health system and accompanying community mental health services.

The SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative is part of the contractual requirements under PATH. As part of the SOAR Initiative, the State has designed and implemented a MT SOAR Strategic Plan (Attachment E, MT SOAR Strategic Plan please contact Mindi Askelson @ MAskelson@mt.gov). MT is using the SOAR Online Training to coordinate SOAR trainings statewide to Mental Health Center case managers and other organizations serving individuals who are homeless or at risk of homelessness. All PATH case managers/liaisons are required to complete the SOAR Online Training.

Housing services are an integral component of the PATH Program and critical to recovery for individuals with SMI and/or co-occurring disorder. The MT PATH Program works closely with the Department of Commerce in the areas of reporting for match requirements and housing grant opportunities.

**Older Adults**

Nationally, the State Health Insurance Assistance Program (SHIP) is an advocacy group whose primary mission is to educate and advocate for Medicare beneficiaries and their families. SHIP counselors frequently work with beneficiaries with varying levels and types of mental illness. As advocates for seniors, as well as adults with disabilities, SHIP counselors are often in the position of assisting individuals whose independence rests, to some extent, on their ability to cope with everyday situations and challenges. The partnership with SHIP and AMDD is providing some basic mental health training and technical support to counselors. As the senior population grows, MT SHIP counselors report they are increasingly consulting with mentally ill beneficiaries, thus partnerships with AMDD are increasingly important.
Youth

CSCT programs are providing access to mental health services through the schools in many rural communities. Some of these include: Eureka, Troy, Trout Creek, Florence, Sheridan, Dillon, Havre, Stevensville, Choteau, Boulder, Ennis, Fort Benton, Miles City, Glendive, and Sidney. CSCT programs in the schools are providing access to mental health services to Native American youth with SED on and near the reservations. Communities served include: Ronan, Polson, Cut Bank, Rocky Boy, Harlem, Lodge Pole, Frazer, Wolf Point, Poplar, and Lame Deer.

MT’s policy is to serve high-risk youth with multi-agency service needs, either in their homes or in the least restrictive and most appropriate setting for their needs, in order to preserve the unity and welfare of the family whenever possible.

Youth in need of emergency psychiatric hospitalization may accesses Acute Inpatient services at Shodair Hospital in Helena, Billings Clinic in Billings, Pathways Treatment Center in Kalispell, or St. Patrick’s Hospital in Missoula.

Youth in need of psychiatric residential treatment must first be referred to the 3 in-State PRTFs: Acadia in Butte, Shodair in Helena, and Yellowstone Boys and Girls Ranch in Billings. When youth in need of PRTF level of care cannot be served in-State, referrals are made to out-of-State PRTFs enrolled as MT Medicaid providers.

An identified gap in community based mental health services was identified as Youth Crisis Diversion Programs (YCDP) across the State. CMHB was appropriated $1,200,000 for the biennium from the 2017 Legislature to fund a statewide Request for Proposals (RFP) process to support communities in the development of local YCDP. This funding would support the development of community programs to enhance the healthy connection between youth crisis diversion facilities and the therapeutic and natural supports the family is already utilizing. Responders are required to develop a program(s) to support crisis diversion that would allow the youth to remain in his/her home community. Funds will be used to augment existing community resources and supports, as well as promoting locally developed, creative, research based solutions that divert youth in crisis. These funds are not available for planning purposes, but for the actual development of a local youth crisis diversion program.

Criterion 5 Management Systems

Financial Resources and Staffing

The AMDD manages program and payment for publicly funded adult mental health and SUD, including the facilities that serve individuals in need of more serious care. The AMDD directly provides services in 3 facilities: the MSH in Warm Springs, MMHNCC in Lewistown, and MCDC in Butte; and contracts with behavioral health providers statewide to provide community-based and inpatient services.
please contact Mindi Askelson @ MAaskelson@mt.gov for a different copy of this chart.
According to the 2017 Presentation to the Health and Human Services Joint Appropriation Subcommittee, 23,398 adults are served by Medicaid programs (both SUD and mental health) the Division oversees in MT communities and more through additional funding streams. Services range from prevention and early intervention services to inpatient, residential, and rehabilitation services. The following chart illustrates the AMDD budget.

The MHSB develops and reimburses for services delivered by community mental health providers in MT’s communities:

- 24,573 adults served in FY2016;
- Community-based programs include Medicaid and other mental health services;
- Provider network includes licensed Mental Health Centers, hospitals, community health centers, licensed practitioners; and
- Funded with combination of General Fund, State Special Revenue, and Federal Funds.

The MHSB is responsible for delivery and reimbursement of MT’s publicly funded community-based mental health services for adults. MHSB administers prevention and early intervention programs, crisis services, core mental health treatment, and those programs that supporting transition and recovery. These programs serve adults with severe mental illness, co-occurring SUDs, and those experiencing a psychiatric crisis. The MHSB oversees a system of behavioral health services with community based providers. Over 24,000 individuals receive services through 1 of these programs, an increase of nearly 48 percent since 2003.
The CMHB supports and strengthens MT youth and families through Medicaid mental health services. The Bureau managed and funded mental health services for over 19,000 youth enrolled in Montana Medicaid in SFY 2016. The CMHB has a budget of approximately $126.3 million with 98 percent funding benefits and claims.

**Training**

MT has incorporated strengths based and recovery oriented services and training in their mental health system. Annually, the Governor’s office provides training focusing on cultural diversity to help staff understand the barriers to health care. Mental Health Centers have developed Crisis Response Intervention (CRI) training for professionals who respond to crisis calls in the community, at the local emergency room, or in the detention center. Many of the emergency rooms contact the trained CRI officers when an individual is in a mental health crisis presents.

MT continues to cultivate a long-standing partnership with Departments of Corrections and Justice to ensure first-responders and emergency health services providers are trained through the nationally recognized CIR model. The 40-hour training is held over the course of a week and includes courses on personality disorders, psychotropic medications and side effects, post-traumatic stress disorder, traumatic brain injury, suicide assessment, and youths’ issues.

The 2017 MT Legislature voted to not only continue, but to also expand funding for the AMDD County and Tribal Matching Grant program for CRI and Jail Diversion. Since 2009, a County Matching Grant program has been in place to address the critical need for crisis intervention and jail diversion in MT communities. To provide appropriate care for those in mental health crisis, many MT communities have no other option but to incarcerate or transport these individuals’ long distances to the MSH, the state’s only public acute psychiatric hospital.

The lack of crisis intervention and jail diversion alternatives means communities must rely on the MSH for emergency and court ordered detention, and evaluation which increases costs for the community, strains the MSH, and diverts resources from community based services. Per Montana Code Annotated 53-21-1201, 53-21-1202, and 53-21-1203, the County and Tribal Matching Grant program funding consists of crisis intervention, jail diversion, insurance coverage against catastrophic pre-commitment costs if an insurance pool is established, and short-term inpatient treatment costs.
Continued Training

State matching funds granted to communities is a way to share costs and provide incentives for local resources to be spent on community-based treatment capacity rather than on jail capacity or on transportation to, and capacity in, the MSH. The program also encourages collaboration between local law enforcement officers, mental health professionals, and private corporations to offer creative sustainable solutions. The match funding was designated to be used to support new projects or enhance current ones. Examples of successful projects supported by matching grant funds in the past include: development of new crisis stabilization facilities, crisis intervention training, and salaries for additional county mental health staff.

Through House Bill 328, the 2017 Montana Legislature revised the statute to offer the matching grant fund opportunity to federally recognized Tribal Governments as well as extend the grant period from 1 year to 2, allowing additional time for counties and tribes to meet the community’s project goals. A local investment county/tribal match is required for these funds. The match rate is determined based upon utilization rates at MSH.

Mental Health First Aid is an adult public education program designed to improve individuals’ knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing 1 or more acute mental health crises or are in the early stages of 1 or more chronic mental health problems. These trainings are held around the State and are free of charge.

Block Grant Designation

The MT Mental Health Block Grant will be designated for the following Priority Areas for 2017-2019 MH Block Grant Dollars Allocation.

1. Implement a model for treatment coordination for those experiencing First Episode Psychosis.
2. Provide required and elective services for MT PATH Program eligible individuals.
4. Provide community and statewide mental health and suicide training and educational opportunities.
5. Create a Transitional Support Program for individuals discharged from the MSH.
PLANNING STEP 2

AMDD funds a broad range of services for many individuals with SMI or SED within MT. However, there are times when these services do not meet all the special needs of certain populations. Analysis of data provided by the MT Center for Mental Health Uniform Reporting System, National Association for Mental Health MT (NAMI MT), and SAMHSA helped us identify 5 critical gaps or unmet mental health service needs of certain populations in MT.

<table>
<thead>
<tr>
<th>CRITICAL GAP AND/OR ADDITIONAL NEED</th>
<th>FUNDED PROGRAM</th>
<th>TARGET POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>66% of individuals with a SMI want to participate in the workforce, yet only 20% are currently employed</td>
<td>Supported Employment</td>
<td>Individuals with SMI</td>
</tr>
<tr>
<td>29.3% of youth reported being depressed for 2 or more consecutive weeks in the past 12 months. The majority of individuals with SMI schizophrenia experience the first signs of illness during adolescence or early adulthood, and there are often long delays between symptom onset and the receipt of evidence-based interventions</td>
<td>FEP</td>
<td>16-25 years old experiencing FEP</td>
</tr>
<tr>
<td>26% of homeless adults staying in shelters live with SMI and an estimated 46% live with SMI and/or SUDs</td>
<td>PATH</td>
<td>Individuals with SMI who are experiencing homelessness</td>
</tr>
<tr>
<td>Between 3 and 16% of those discharged from MSH were readmitted within the first 6 months</td>
<td>TSP</td>
<td>Individuals with SMI in rural areas</td>
</tr>
<tr>
<td>Reduce the stigma of mental illness and to improve the care and treatment of individuals with mental illness</td>
<td>NAMI MT Training/Conference</td>
<td>Adults with SMI Youth with SED Older Adults with SMI</td>
</tr>
</tbody>
</table>

**Individuals with SMI in the Workforce**

MT is expected to experience a critical shortfall of workers over the next 10 years. According to the *Missoulian*, “Due to an aging population and faster-than-average economic growth rates, MT's labor force is not expected to keep up with businesses' demand for workers over the next 10 years. MT’s labor force is about 500,000 workers right now, but the State is expected to lose 120,000 baby boomers to retirement over the next decade.” With only 80,000 to 90,000 younger workers entering into the MT workforce, businesses can’t find enough skilled workers.

Juxtaposed to this worker shortage, NAMI’s current national data shows that SMI costs America $193.2 billion in lost earnings per year. Employment for those with SMI is an essential part of recovery as well as being a cost-effective alternative to day treatment. Steady employment improves self-esteem and social networks. It increases quality of life and reduces SUD and use of mental health services. Research done by the MT Center for Mental Health Uniform Reporting System, shows that 66 percent of individuals with a SMI say they want to work however, only less than 20 percent are working.
Supported Employment may be the answer to both MT’s skilled worker shortage as well as the nation’s lost earnings. Supported Employment refers to services provided to an individual with a SMI to assist them in obtaining and maintain competitive employment. Currently, supported employment is funded through the MHBG.

![Percent of Individuals with SMI in the Labor Force](image)

*Denominator is Employed + Unemployed

Source: MT Center for Mental Health Uniform Reporting System 2015

**FEP**

Research done by The National Institute of Mental Health (NIMH) has shown, “that if left untreated, young adults experiencing psychosis are more likely to develop SMI such as schizophrenia.” Additional research done by the MT Office of Public Instruction found, “The proportion of youth who report being depressed for 2 or more consecutive weeks in the past 12 months has increased from 26.4 percent in 2013 to 29.3 percent in 2015.” However, according to NAMI, only 51 percent for youth aged 8-15 received mental health services in the previous year. Youth and adolescents who do not receive mental health services show a greater decrease in functioning such as:

- Loss of educational opportunities;
- Impaired psychosocial and vocational development;
- Personal suffering/family burdens; and
- Potential poorer response once treatment is provided.

To address these issues, the CMHB is working to improve early access to mental health services by providing FEP services to 16-25 years old experiencing FEP.

Early Psychosis Intervention Clinic (EPIC) is a partnership between Billings Clinic, a nonprofit integrated health system located in Billings, South Central MT Regional Mental Health Center, and NAMI MT. They have chosen to use Yale’s Specialized Treatment Early in Psychosis (STEP) model, which is based on an interdisciplinary team approach to providing comprehensive care for individuals early in the onset.
of a psychotic illness. STEP starts with thorough assessment in order to gain the best understanding of what may be causing the individual’s difficulties. Then, based upon individual needs and preferences, treatment may include medication management, community coaching, individual and group therapy, as well as support and education for family members and friends. The goal of EPIC is, “To measurably improve outcomes for individuals within our 6 MT county service area (Gallatin, Park, Sweet Grass, Stillwater, Carbon, and Yellowstone), aged 16-25, who experience a recent onset of psychosis by accelerating and increasing access to coordinated specialty care.”

**Individuals Who Are Experiencing Homelessness**

According to NAMI, an estimated 26 percent of homeless individuals staying in shelters live with SMI and an estimated 46 percent live with severe mental illness and/or SUDs. MT’s 2016 PIT count identified 1,486 individuals who were homeless on January 28, 2016. Of those individuals identified as homeless, 298 are living with a SMI and 186 identified as chronic substance users. In MT’s fight to reduce or eliminate homelessness for individuals with SMI or co-occurring SMI and SUDs or who are at imminent risk of becoming homeless, PATH funds are used to provide a menu of required services, which are not supported by mainstream programs. Through its services, PATH links a vulnerable population who experience persistent and pervasive health disparities to mainstream and other supportive services. Collectively, these efforts help homeless individuals with SMI secure safe and stable housing, improve their health, and live a self-directed, purposeful lives. The PATH Program is part of SAMHSA’s Recovery Support Strategic Initiative which includes goals to improve the physical and behavioral health of individuals with behavioral health disorders, increase access to permanent housing, increase attainment of employment, and increase social supports.

![Rate of All Consumers Homeless/in Shelters](https://example.com/rate-graph.png)

**Rate of All Consumers Homeless/in Shelters**

**MT vs. U.S.**

**2009 - 2015**

Source: MT Center for Mental Health Uniform Reporting System 2015

In MT, PATH Programs serve as the front door to Continuum of Care (CoC) services and to mainstream behavioral health, primary health care, and substance abuse service systems. MT PATH Programs use existing capacities to leverage services and supports or propose ways that this capacity will be developed, i.e., through community CoC committees. MT PATH Programs are more than a stand-alone response to the needs of MT PATH Program eligible individuals and MT PATH Program funds are used in projects...
that link with other services and providers to develop comprehensive approaches to community services. Below is a list of required services PATH funds are used for:

- Evidenced based outreach approaches;
- Evidenced based inreach approaches;
- Enrollment in MT PATH Program;
- Case management for at least 3 months;
- Prescription renewal;
- Medication management;
- Referral to community behavioral health services, including support services;
- Referral to primary health services, dental services, job training, education services, and housing services; and
- Case management intake, prescription renewal, and medication management services.

Medications play an important part of an individual’s treatment plan and are usually more effective when combined with psychotherapy. According to NAMI, “In some cases, medication can reduce symptoms so that other methods of a treatment plan can be more effective. For example, a medication may alleviate some significant symptoms of major depression and then talk therapy can help you change negative patterns of thinking.” For these reasons, AMDD has chosen to use MHBG funding to support the MT PATH Program.

**TSP**

According to admission and discharge data, MSH provided inpatient psychiatric treatment for approximately 900 adults with SMI in FY 2016. That same data also revealed between 3 and 16 percent of those discharged from MSH were readmitted within 6 months. The reason for readmissions are varied, but some reasons fall within 2 categories: lack of primary support and treatment access. According to the enrollment specialist at MSH, patients’ non-compliance with medication and inability to access community mental health supports in a timely manner is common.

All of MT’s 56 counties have been designated as health care provider shortage areas for mental health services. In fact, MT has the largest and most severe mental health shortage in the entire United States. “The eastern MT Mental Health Professional Shortage Areas includes 78,607 MT Residents and is spread over 17 counties and 47,945 square miles.” The lack of community based mental health services can be detrimental to the recovery of those individuals leaving MSH, MT’s only public psychiatric hospital.

(Attachment B, MT Health Care and Innovation Plan)

**Source:** MT Center for Mental Health Uniform Reporting System 2015
To address the issue of hospital readmission MT will use Block Grant fund to start a TSP. The purpose of the TSP is to provide 60 days of post-discharge support for individuals leaving MSH. TSP is intended to be the bridge between intensive care and support received at MSH and a successful warm handoff to the community. The TSP will be responsible for:

- Implementation of the individuals discharge plan;
- Assisting with scheduling of appointments for clinical services;
- Arranging non-clinical services and supports;
- Identifying resources that are available in the community;
- Transportation;
- Medication management; and
- Providing 60 days of post-discharge support.

**Mental Health Training and Educational Opportunities**

The number of individuals accessing mental health services in MT has steadily increased from 38,031 in 2013 to 49,935 in 2016. This increase in utilization of services correlates with the increase in the number of Montanan’s who have taken part mental health training and educational opportunities offered across the State offered by AMDD and NAMI MT.

AMDD and NAMI MT have enjoyed a close affiliation for many years. Together they have worked to eliminate the stigma of mental illness and to improve the care and treatment of individuals with mental illness. This year AMDD will contract with NAMI MT to use the MHBG to:

- Provide scholarships to individuals to the NAMI MT State Conference on Mental Illness;
- Bring in national speakers to the NAMI MT conference;
- Send individuals to the National NAMI Headquarters for Train the Trainer opportunities;
- Provide Continuing Educational Units (CEU) to mental health providers; and
- Offer a variety of educational programs, free of charge, to communities across the State.
Number of Adult Consumers Served by Age Group
FY2008-FY2015

Sources: MT Center for Mental Health Uniform Reporting System 2015
QUALITY AND DATA COLLECTION READINESS

Briefly describe the State’s data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

MT’s primary current data collection and reporting system, Medicaid Management Information System (MMIS) is not just specific to SUD and/or mental health. MMIS is a much larger data system in which information is collected for all Medicaid claims data for individuals of all ages whose Montana Medicaid services are funded by State and Federal dollars. We do not have access to data on all the MT residents receiving mental health services who have funding sources other than Federal and State dollars.

There are a number of demographic fields available in relation to individuals receiving services (member identification, date of birth, name, gender, race, address, phone number, deprivation code, etc.) which allow MT to report at the individual member level. Data on services is also available by provider type and location of service.

Currently there is only the Recovery Marker data collection and reporting system to provide us with the housing and employment data; however, the data is not collected on many individuals. Recovery Markers are individual-level data used to quantitatively measure recovery among MT’s publicly funded mental health individuals. Measures include employment status, residential situation, substance use, physical health and care, education level, criminal status, referral source, and reason for discharge. Recognizing the need to improve our data infrastructure, MT has implemented a health information technology (IT) transformation plan that includes 3 components:

- A collaboration between MT Medicaid and the State Employee Health Plan to enhance MT’s claims data analysis capabilities.
- Minimal IT infrastructure and free software for the Project Extension for Community Healthcare Outcomes (ECHO) enhanced collaborative care model. Billings Clinic, MT’s hub site, already had the necessary teleconferencing equipment in place, and spoke sites need only a web cam and an internet connection.
- A Health Information Exchange (HIE) pilot project, which will begin by identifying the high-cost, high-needs individuals for MT’s hot spotting project, as well as facilitate automatic data quality reporting for MT’s Patient Centered Medical Home (PCMH) program (as described in the Parity and Integration section).

Is the State's current data collection and reporting system specific to substance use and/or mental health services individuals, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

MT’s current data collection and reporting system has both reporting systems that are not specific to SUD as well as 1 that is specific SUD. We have access to Criminal Justice data through a Memorandum of Understanding with the MT Department of Justice. MT has data collection and reporting systems specific to mental health such as Recovery Markers, the Mental Health Statistics Improvement Program Consumer Satisfaction Survey, and MSH data most of which is not in MMIS. SUD data has the Substance Abuse Management Information System (SAMS). The CD Bureau collects data for measures of Recovery:

- Abstinence (change in frequency of use);
- Employment;
- Education;
- Criminal justice involvement;
- Housing;
- Number of individuals served by the Substance Abuse Block Grant (SABG); and
- Participation in self-help groups.
Is the State currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?

Yes

PARITY AND INTEGRATION

Answer to question 1

HRD administers Medicaid primary care services including HMK/CHIP. The Division’s purpose is to improve and protect the health and safety of Montanans. The Division reimburses private and public providers for a wide range of preventative, primary, and acute care services. Major service providers include: physicians, mid-levels, public health departments, clinics, FQHC, IHS, Tribal Health Departments, hospitals, dentists, pharmacies, and durable medical equipment.

Transitioning Youth at a Healthy Age (SYT-I)

SYT-I is a 3-year SAMHSA funded grant from 9/29/2015 to 9/29/2018. The grant addresses the critical need for providing evidence-based care to adolescents and transitional age youth with SUD and co-occurring disorders by improving the infrastructure for, and access to, treatment and recovery services. All efforts are overseen by an interagency council that includes State agencies, family, and youth members.

Evidenced-based care provided by the SYT-I grant:

- IJ for individuals ages 16 to 25 with SUD and mental health disorders and their families. This model is already used by Native American provider organizations in some rural communities in MT;
- 4 treatment providers implementing the model at sites in Helena, Billings, Havre, and Great Falls;
- Using it in conjunction with a variety of treatment services and with support from others, including peers and family members
- Offering family members the opportunity to journal about their experience and to better understand the basics of alcohol and other drug and addiction and the impact of the disease has on all members of the family; and
- Identifying what recovery and support services are available and needed by families and youth in the 4 communities.

Patient Centered Medicaid Home (PCMH)

In 2014, the MT Medicaid PCMH was introduced. PCMH is a team of healthcare professionals who transformed their focus from just treating illness after the fact to keeping individuals healthy and avoiding expensive complications. A PCMH utilizes a “team” of people in various positions, such as physicians, physician assistants, nurse practitioners, nurses, care coordinators, dieticians, behavioral health consultants, and pharmacists to coordinate all aspects of individuals’ health. The care team engages individuals as an active participant in their healthcare through better communication regarding the individual’s responsibility for their own health. PCMHs provide a comprehensive approach to healthcare, addressing every aspect of individuals’ health, at all stages of life. PCMHs coordinate care with other parts of the healthcare system such as specialty healthcare providers, hospitals, and nursing homes. Some PCMHs also connect individuals to community resources such as affordable housing or affordable health insurance. PCMHs prevent and manage disease better by following up with individuals to ensure that preventive care and necessary treatment for chronic disease is delivered in a timely and appropriate manner.
Comprehensive Primary Care Plus (CPC+)

In January 2017, MT became 1 of the 14 national locations to introduce the CPC+ model. CPC+ is a new, innovative, value-based 5-year payment and delivery reform model that takes this aim to the next level in partnership with primary care practice. CPC+ gives practices the flexibility to deliver primary health care in more innovative ways, in the manner that best meets individuals’ needs, without being tethered to the 20-minute office visit. It allows practices to pool this “non-visit based funding” from multiple public and private payers and apply it to a whole-population proactive primary care management strategy and agree to take on upside and downside risk.

Practices across MT may participate in 1 of 2 CPC+ tracks. In Track 1, each payer will pay practices a monthly per member per month care management fee in addition to regular fee-for-service payments. In Track 2, practices will receive the monthly fee, as well as hybrid payments to allow greater flexibility in how practices deliver care. Practices in Track 2 will be expected to provide more comprehensive services. To promote high quality and valued care, practices in both tracks will receive performance-based incentive payments.

Answer to question 2

MT is fortunate to have both the CBD, the SUD treatment system, and the MHSB, the adult mental health system, located under AMDD. While MT provides for the establishment CoC to provide for individuals with mental illness and SUD, including those with a co-occurring mental illness and SUD, the integration of co-occurring services within each treatment modality continues to be a work in process as many areas do not have the professionals to address the complexities of co-occurring behavioral health issues.

Many SUD services are provided through contracted State approved programs. The current provider system is a statewide system which provides SUD treatment through 31 State-approved programs. This includes 3 Tribal Health and 3 Urban Center Native American programs, and 5 FQHCs (2 urban, 1 urban Native American, and 2 frontier/rural programs). Of the 31 contracted agencies, 19 of the agencies are: integrated into mental health agencies; employ a full continuum of mental health staff to provide services; or contract mental health services to be performed by the appropriate licensed mental health personnel. These 22 agencies provide integrated mental health services for both youth and adults (birth to death). MT’s current SUD treatment capacity within this system is approximately 7,000 people a year.

AMDD also administers MCDC, the only State administered in-patient SUD/co-occurring SUD/mental illness facility. Significant to the evolution of treatment at MCDC is the recognition and implementation of integrated treatment for individuals with co-occurring disorders. Medication in treatment is now a factor in stabilizing and treating individuals to more effectively participate in their treatment. MCDC utilizes an interdisciplinary team consisting of physicians, nurses, mental health therapists, addictions counselors, and treatment aides.

There are 2 providers of inpatient SUD treatment for Medicaid eligible youth, Rimrock in Billings, MT, and Teen Recovery in Missoula, MT. Outpatient services are available in several communities, but the providers often have a waiting list. Although co-occurring disorders are presumed to be common with older youth, most providers of public mental health services for youth are not trained to provide integrated services for youth with co-occurring disorders.
The CMHB has managed 2 SAMSHA grants piloting projects to address co-occurring disorders in transition age youth. The first began September 30, 2012, and focused on the following:

- Established a learning laboratory by collaborating with local community based mental health treatment providers (sites) interested in delivering ICT;
- Improved outcomes for youth who receive ICT;
- Increased the number of professionals trained and licensed to provide co-occurring treatment, recovery/support to MT youth; and
- Increased funding sources for ICT and the number of youth who receive ICT.

This grant expired in 2016 and MT sustained the ICT program through Medicaid funding.

The second grant, SYT-I, is a 3 year grant addressing the critical need for providing evidence-based care to adolescents and transitional age youth with SUD and co-occurring disorders by improving the infrastructure for and access to treatment and recovery services. Activities are focused on building workforce capacity, addressing policy and funding barriers, and better engaging youth and caregivers in designing systems and implementing evidence-based care.

The MT Project LAUNCH Initiative (MT-PLI) is the third grant that will allow MT to directly address the problem of mental health service access and infrastructure for young children and families in the State, by utilizing the Center for Social and Emotional Foundations for Early Learning's Pyramid Model for Promoting Social Emotional Competence in Infants and Young Children as a framework. The MT-PLI will engage early childhood partners to improve systems and access to mental health services for youth by piloting evidence-based practices in Gallatin and Park Counties. MT’s strategy also focuses on the coordination of family support services, including evidence-based home visiting, as well as the enhancement of parent skills training.

**Answer to question 3**

AMDD does a retroactive Medicaid review of individuals and families who have accessed mental health services claimed through the MMIS system. In addition, AMDD administers the Mental Health Statistics Improvement Program Consumer Satisfaction Survey to assess member’s level of satisfaction regarding mental health services and their ability to access mental health services. The 2016 survey results indicate 74 percent of adults surveyed reported feeling positively about their access to mental health services.
Answer to question 4

The State can track the number of individuals who accessed M/SUD services, but there is no State mandate to monitor access to mental health/SUD services by the Qualified Health Plan (QHP).

Answer to question 5

Care coordination occurs regularly between mental health and chemical dependency services. Other opportunities are considered as funding becomes available.

The 2016 Governor’s Council on Health Care Innovation and Reform (Attachment B, MT Health Care and Innovation Plan) was charged with:

- Identifying opportunities to improve care delivery;
- Controlling costs; and
- Improving system performance and population health through coordination of the public and private sectors.

The BRFSS is the primary source of State-based information on health risk behaviors among the adult population 18 years of age or older living in households. BRFSS gathers information from individuals about a wide range of behaviors that affect their health. The primary focus of these surveys is on behaviors that are linked with the leading causes of death; heart disease, cancer, stroke, diabetes, injury, and other important health issues.

The information collected is used to:

- Improve health care for Montanans;
- Monitor the effectiveness of health intervention and services;
- Address critical and emerging health issues;
- Educate the public, health practitioners, and policy makers about health risk behaviors and conditions; and
- Measure progress toward achieving State and National health objectives.
Answer to question 6 is on Parity and Integration. PDF please contact Mindi Askelson @ MAskelson@mt.gov for this PDF

Answer to question 7

The 2016 Governor’s Council on Health Care Innovation and Reform (Attachment B, MT Health Care and Innovation Plan) was charged with:

- Identifying opportunities to improve care delivery;
- Controlling costs; and
- Improving system performance and population health through coordination of the public and private sectors.

CPC+

In January 2017, MT became 1 of the 14 locations to introduce CPC+ model. CPC+ is a new, innovative, value-based 5-year payment and delivery reform model that takes this aim to the next level in partnership with primary care practice. CPC+ gives practices the flexibility to deliver primary health care in more innovative ways, in the manner that best meets individuals’ needs, without being tethered to the 20-minute office visit. It allows practices to pool this “non-visit based funding” from multiple public and private payers and apply it to a whole-population proactive primary care management strategies and agree to take on upside and downside risk.

Practices across MT may participate in 1 of 2 CPC+ tracks. In Track 1, each payer will pay practices a monthly per member per month care management fee in addition to regular fee-for-service payments. In Track 2, practices will receive the monthly fee, as well as hybrid payments to allow greater flexibility in how practices deliver care. Practices in Track 2 will be expected to provide more comprehensive services. To promote high quality and valued care, practices in both tracks will receive performance-based incentive payments.

The MT-PLI, administered by the Early Childhood Services Bureau, is a grant that will allow MT to directly address the problem of mental health service access and infrastructure for young children and families in the State, by utilizing the Center for Social and Emotional Foundations for Early Learning’s Pyramid Model for Promoting Social Emotional Competence in Infants and Young Children as a framework. The MT-PLI will engage early childhood partners to improve systems and access to mental health services for youth by piloting evidence-based practices in Gallatin and Park Counties. MT’s strategy also focuses on the coordination of family support services, including evidence-based home visiting, as well as the enhancement of parent skills training.

Answer to question 8

The Mental Health Parity and Addiction Equity Act of 2008 is the governing the payment of mental health claims in MT. The act, “…prohibits self-funded employer group health plans and all health insurance issuers from imposing more restrictive limitations on mental health and SUD treatment benefits than on physical health benefits.”

MT has the largest and most severe mental health shortage are in the entire United States. As stated in the Health Care Innovation Plan (Attachment B, MT Health Care and Innovation Plan), according to the Health Resource Services Administration, all of MT’s 56 counties have been designated as health care provider shortage areas for mental health services. “The eastern MT Mental Health Professional Shortage Areas includes 78,607 MT Residents and is spread over 17 counties and 47,945 square miles.” (Attachment B, MT Health Care and Innovation Plan) This shortage necessitates the use of telehealth services for the delivery of physical, substance use, and mental health services. In 2015, MT passed a law
that required private payers to cover certain telehealth services in the manner equivalent to in-person services.

The 2017 Legislature amended the MT Mental Health Parity Act via House Bill 142. This ensured that the MT law applies for the same level of parity between mental health and physical health benefits as existed in the Federal law on January 1, 2017. To date, AMDD has attended 3 webinars sponsored by the Centers for Medicare & Medicaid Services and are in the process of establishing the work group to identify, establish, and create the processes and criteria to meet mental health parity, including the coordination of SUD and mental health services.

**Answer to question 9**

According to the 2016 Governor’s Council on Health Care Innovation and Reform (Attachment B, MT Health Care and Innovation Plan), MT has seen many innovative and promising pilot programs, efforts have historically been funded with small amounts of one-time grant funding, are not always well coordinated, and when funding is exhausted, many of the efforts have folded. Aligned approaches that drive sustained and large-scale delivery system change are a challenge given the State’s geography and limited resources. However, as a Department, we are committed to finding new ways to sustain promising initiative.
HEALTH DISPARITIES

Question 1

MT LGBT population is estimated to be less than 1 percent.

Question 2

Go To:
(Attachment B, MT Health Care and Innovation Plan);
(Attachment C, MT Native Youth Suicide Reduction Strategic Plan); and
(Attachment F, Behavioral Risk Factor Surveillance System). Please contact Mindi Askelson @ MAskelson@mt.gov For this attachment.

The MT Health Care and Innovation Plan (Attachment B, MT Health Care and Innovation Plan) identified specific concerns surrounding the connection between mental or behavioral health and chronic conditions or chronic disease risk factors. This concern is demonstrated in the data, for example, 1/5 of respondents to the BRFSS survey reported experiencing between 1 and 13 days of poor mental or emotional health in the month prior to the survey; 11 percent reported experiencing 14 or more days. The remaining 2/3 did not report experiencing poor mental or emotional health.

The MT Health Care and Innovation Plan (Attachment B, MT Health Care and Innovation Plan) also identified concerns regarding the significant disparities between American Indian and non-Indian health access, status, and outcomes. Improving health equity and reducing such disparities must be a priority for MT. Unfortunately, many American Indians go without adequate health care for a variety of reasons. Although access to care is a concern for all rural residents, it is even more dire for American Indians. Nearly 2/3 of American Indian residents in MT live in medically underserved counties, and more frequently report barriers to care access than non-Indian residents, including lack of access to primary care and preventative services like screening, testing, and check-ups. Lack of access, in combination with other social determinants, ultimately contributes to Indians dying a generation younger than non-Indians.

The age-adjusted mortality rate for non-Indian residents of MT was substantially lower than for American Indian residents: 742.6 per 100,000 compared to 1,184.6 per 100,000. In addition, the mortality rates for many individual causes of death were lower for non-Indian residents than for American Indian residents.

According to the MT Native Youth Suicide Reduction, (Attachment C, MT Native Youth Suicide Reduction Strategic Plan) suicide is the second leading cause of death among American Indian adolescents and young adults, at a rate 2.5 times higher than the national average. Rates for death by suicide among non-Indian populations peak in older adulthood, whereas rates of death by suicide among Indian populations peak during adolescence and young adulthood. MT’s tribes are taking significant actions to address Indian youth suicide at local, tribal, intertribal, and organizational levels. The MT Native Youth Suicide Reduction Strategic Plan, Attachment C, offers more details on these programs.

MT Medicaid has established an equality of care and gender parity criteria, policy, and transgender reassignment work group meeting periodically to complete reviews to remove, override, or create necessary exceptions for medical reimbursement and benefit plan design to meet Federal law.
**Question 3**

MT is made up of 91 percent Caucasian, 7 percent American Indian, and 2 percent of all other ethnicities. Other language needs are identified by providers on an individual basis. MT Medicaid reimburses for interpreter services when needed.

**Question 4**

Go To (Attachment B, MT Health Care and Innovation Plan).
INNOVATION IN PURCHASING

**Question 1** - Go to Innovation in Purchasing.pdf

Please contact Mindi Askelson @ MAskelson@mt.gov For PDF docs

**Question 2** – Go to Innovation in Purchasing.pdf

MT has historically allocated a significant portion of the MHBG to the purchase of evidence-based or promising practices. FFY 2018-2019 MHBG dollars were used to support:

- Individual Placement and Supports Employment Programs;
- Yale STEP Program (based on the NAVIGATE model);
- MT PATH Program required/elective services;
- Statewide trainings and conferences that highlight evidence based practices in behavioral health; and
- CEU training options for current providers that are evidence based practices in behavioral health.
EVIDENCE-BASED PRACTICES FOR EARLY INTERVENTIONS TO ADDRESS EARLY SERIOUS MENTAL ILLNESS (ESMI) 10 PERCENT SET ASIDE’1-

Does the State have policies for addressing early serious mental illness (ESMD)?

No

Has the State implemented any evidence based practices (EBPs) for those with ESMI?

Yes

If yes, please list the EBPs and provide a description of the program that the State currently funds to implement evidence-based practices for those with ESMI.

Interactive Journaling (IJ) is used for 16 to 25 year olds with SUD and mental health disorders and their families. IJ is used in conjunction with other treatments with the support from peers and family members. Journaling about their experience can help individuals better understand the basics of alcohol and other drug addiction and the impact on the disease on all members of the family. EPIC, which is based on the NAVIGATE model, is used for 16-25 year olds with FEP. NAVIGATE is a “comprehensive program designed to provide early and effective treatment to individuals have experienced a first episode of psychosis (FEP)”. NAVIGATE is the program developed with support from the NIMH and is one of the options for implementation as described by SAMHSA. NAVIGATE is a team-based approach, which includes the following team members:

- Program Director;
- Prescriber;
- Individual Resiliency Trainer;
- Family Education Clinician;
- Supported Employment and Education Specialist; and
- Case Management provided by either a specific case manager or 1 of the team members.

Does the State coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI?

No

Does the State provide trainings to increase capacity of providers to deliver interventions related to ESMI?

Yes

From both the Transitioning Youth at a Healthy Age (SYT-I).

Does the State provide trainings to increase the capacity of providers to deliver interventions related to ESMI?

Yes

Through both the SYT-I.

Does the State collect data specifically related to ESMI?

Yes

Please provide an updated description of the State's chosen EBPs for the 10 percent set-aside for ESMI.

EPIC, which is based on the NAVIGATE model, is used for 16-25 year olds with FEP. NAVIGATE is a “comprehensive program designed to provide early and effective treatment to individuals have
experienced a FEP”. NAVIGATE is the program developed with support from the NIMH and is one of the options for implementation as described by SAMHSA. NAVIGATE is a team-based approach, which includes the following team members:

- Program Director;
- Prescriber;
- Individual Resiliency Trainer;
- Family Education Clinician;
- Supported Employment and Education Specialist; and
- Case Management provided by either a specific case manager or 1 of the team members.

**Provide a description of the programs that the State currently funds to implement evidence-based practices for those with ESMI.**

Research done by NIMH has shown, “that if left untreated, young adults experiencing psychosis are more likely to develop SMI such as schizophrenia.” Additional research done by the MT Office of Public Instruction found, “The proportion of youth who report being depressed for 2 seems like past documents have spelled the small numbers, whatever just consistent or more consecutive weeks in the past 12 months has increased from 26.4 percent in 2013 to 29.3 percent in 2015.” However, according to NAMI, only 51 percent for youth aged 8-15 received mental health services in the previous year. Youth and adolescents who do not receive mental health services show a greater decrease in functioning such as:

- Loss of educational opportunities;
- Impaired psychosocial and vocational development;
- Personal suffering/family burdens; and
- Potential poorer response once treatment is provided.

To address these issues, the CMHB is working to improve early access to mental health services by providing FEP services to 16-25 year olds experiencing FEP.

EPIC is a partnership between Billings Clinic, a nonprofit integrated health system located in Billings, MT, South Central MT Regional Mental Health Center, and NAMI MT. They have chosen to use STEP, which is based on an interdisciplinary team approach to providing comprehensive care for individuals early in the onset of a psychotic illness. STEP starts with thorough assessment in order to gain the best understanding of what may be causing the individual’s difficulties. Then, based upon individual needs and preferences, treatment may include medication management, community coaching, individual and group therapy, as well as support and education for family members and friends. The goal of EPIC is, “To measurably improve outcomes for individuals within our 6 MT county service area (Gallatin, Park, Sweet Grass, Stillwater, Carbon, and Yellowstone), aged 16-25, who experience a recent onset of psychosis by accelerating and increasing access to coordinated specialty care.”

IJ is used with for 16 to 25 year olds with substance abuse and mental health disorders and their families. It is used in conjunction with other treatments with the support from others, including peers and family members. Journaling about their experience can help individuals better understand the basics of alcohol and other drug addiction and the impact on the disease on all members of the family.

**How does the State promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?**

The provider has designed printed material and awareness advertisement for print and radio media. The informational materials and advertisements will concentrate on transition age youth serving institutions and agencies and will supplemented by outreach to primary care providers participating in Project ECHO. Project ECHO is a teleconsultation tool to provide local prescribers a direct line to clinicians who
specialize in caring for individuals who have been exposed to trauma. It is also expected that referrals will come from self/family, primary care, school and university counseling offices, psychiatric hospitals, and possibly community social service agencies.

**Please describe the planned activities for FFY 2018 and FFY 2019 for your State's ESMI programs including psychosis?**

The current pilot project, EPIC, is in its early stages. As the program continues to grow and evolve, we will explore the validity of the outcomes and the possibility of expanding the program to the rest of the State. In addition, we are looking at possibilities for sustainability and ways of incorporating various funding mechanisms.

**Please explain the State's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.**

The provider reports to the CMHB quarterly data. The provider is currently reporting on the following metrics:

- The duration from onset of symptoms to first medication will be less than 3 months;
- The duration from onset of symptoms to evaluation for enrollment in EPIC will be less than 12 months;
- Equal distribution of male/female individuals in the program;
- 50 percent of program eligible individuals admitted to a psychiatric unit in the hospital will be admitted to the EPIC program;
- 75 percent of individuals enrolled in the program will still be active in the program by the end of the second year;
- 75 percent of individuals enrolled in the program will have 1 or more family members attend an education session within 1 month of admittance to the program;
- 75 percent of individuals enrolled in the program will attend at least 1 social cognition and interaction therapy within 12 weeks of admittance to the program; and
- 25 percent or less of individuals enrolled in the program will be admitted to a psychiatric hospital or crisis center within 6 months and 1 year for admittance to the program.

The process and outcome measures established for the program are:

- Access (Outcome)
  - Rapidity of access;
  - Equity of access; and
  - Pathway to care.
- Engagement (Outcome)
  - Overall;
  - Family;
  - Social skills;
  - Work/school;
  - Hospitalization;
  - Suicidality;
  - Remission;
  - Recovery
  - Work/school engagement;
  - Primary care engagement; and
  - Caregiver burden.
- Weekly team meeting (Process);
- Outreach plan (Process);
- Data sharing plan (Process)
- Capability development (Process);
- Documentation (Process); and
- Documentation/formative and summative reporting (Process).

**Please list the diagnostic categories identified for your State's ESMI programs.**
Schizophrenia Spectrum;
Bipolar and Related Disorders;
Depressive Disorders;
Anxiety Disorders;
Obsessive-Compulsive and Related Disorders;
Trauma and Stressor Related Disorders;
Dissociative Disorder;
Feeding and Eating Disorders;
Gender Dysphoria;
Neurodevelopmental Disorder; and
Disruptive, Impulse-Control, and Conduct Disorder.

**PERSON CENTERED PLANNING**

**Does your State have policies related to person centered planning?**
Yes

**Describe how the State engages consumers and their caregivers in making the health care decisions, and enhance communication.**
AMDD’s SDMI 1915(c) Waiver is designed to engage members and their caregivers in making health care decisions with a Person-Centered Recovery Plan (PCRP). The PCRP is a written plan for services developed by the Case Management Team (CMT) and members using a person-centered, strengths based approach to assess and determine members’ status and needs. The PCRP also outlines the services that will be provided to members to meet their identified needs. An initial PCRP can be developed prior to the members’ enrollment. The final plan must be completed with members within thirty days of enrollment. Subsequent plans of care must be reviewed at least quarterly or when the members’ condition warrants it. The CMT must have members actively participate in creating the PCRP. The CMT may also consult family members, relatives, personal representative, psychologists, healthcare professionals, and other consultants as necessary, with the members’ approval.

Each individual PCRP shall include at least the following components:
- Diagnosis, symptoms, complaints and complications indicating the need for services;
- A description of the individual's functional level;
- The individual's specific short-term objectives and long-term goals;
- A discharge plan which describes elements necessary for independence;
- Must include a minimum of 2 services. Case Management will not be counted as 1 of the services. It is not acceptable to have only residential and case management services;
- Any orders such as medication, treatments, restorative and rehabilitative services, activities, and therapies, etc.;
- The specific services to be provided, the frequency of services and the type of provider;
• A psychosocial summary describing the individual’s social, emotional, mental and financial situation attached to the initial PCRP;
• A Strengths Assessment will be used to identify the individual’s strengths, needs, resources, past successes, and formal and informal supports;
• A psychological crisis intervention plan which includes;
  o Medical crisis intervention plan;
  o Formal (including state plan services) and informal supports and services; and
  o Emergency back up and evacuation plan (short and long term); and
• A cost sheet which projects the annualized costs of PCRP.

Describe the person-centered planning process in your State.
Reference above.

SELF DIRECTION

Does your State have policies related to self-direction?
Yes. The State has policies related to self-direction in the SDMI 1915(c) Waiver.

Are there any concretely planned initiatives in our State specific to self-direction?
The State has policies related to self-direction in the SDMI 1915(c) Waiver.

If yes, describe the currently planned initiatives. In particular, please answer the following questions:
• How is this initiative financed? Via the SDMI 1915(c) Waiver.
• What are the eligibility criteria?
  o Medicaid eligible;
  o Meet SDMI criteria;
  o Be 18 or older;
  o Meet nursing facility level of care;
  o Chose to receive waiver services; and
  o Reside in an area within the State where the waiver is available and there is capacity.

How are budgets set, and what is the scope of the budget? The SDMI 1915(c) Waiver budget is set by a capped number of members. All services are available if specified in the members PCRP.

What role, if any, do peers with lived experience of the mental health system play in the initiative?
Peer services is an available service in the SDMI 1915(c) Waiver.

What, if any, research and evaluation activities are connected to the initiative?
None at this time.

If no, describe any action steps planned by the State in developing self-direction initiatives in the future.
None at this time.
PROGRAM INTEGRITY

Question 1
Federal Program requirements are conveyed through the contract process and the Administrative Rules of MT. The Block Grant Program Planner communicates with contracted providers monthly to review progress in the following areas:

- Community involvement;
- Data collection and quality;
- Progress towards intended outcomes; and
- Partnerships and collaborations.

In addition, the providers submit a Budget, Invoice, and Actual Expenditures sheet monthly, which provides the Block Grant Program Planner key information about the impact of the various funded activities. Quarterly fiscal data is reviewed by the Block Grant Program Planner who approves all expenditure sheets prior to reimbursement to ensure appropriateness and timeliness of the expenditures.

Desk audits will be performed annually to provide an accurate and objective analysis of service delivery and administration Block Grant programs at the provider level.

Question 2
Through annual contract review, coaching, technical assistance, training, and the review of the monthly Budget, Invoice, and Actual Expenditures sheet. Based on this information if a corrective action plan is warranted, one is issued and monitored for compliance.

TRIBES

How many consultation sessions has the State conducted with Federally recognized tribes?

DPHHS holds in high regard the government-to-government relationships that have been built with the tribal governing bodies and their respective Tribal Health Departments. DPHHS conducts an annual tour across MT with assistance from the agency’s Tribal Relations Manager. The DPHHS Director, State Medicaid Director, and Tribal Relations Manager travel to each reservation to make personal visits to every tribal governing body (tribal council). These meetings provide an opportunity to discuss the Medicaid program and allows DPHHS to continue to learn more about how health care is delivered in each tribal community. Similar visits have been made to the IHS Units. The goal of these visits is to promote a relationship of cooperation, coordination, open communication, good will, and respect to enter into fair agreements with Tribal Governments.

In addition, DPHHS has a government-to-government policy on negotiations with Tribal Governments, which became effective in 2011. (Attachment G, Tribal Consultation) Please contact Mindi Askelson @ MAskelson@mt.gov Attachment DPHHS consults with Tribal Governments on major new changes or significant policy or administrative amendments that are determined to have Tribal Government implications. DPHHS also holds annual or more frequent Medicaid Tribal Consultation meetings.
STATUTORY CRITERION FORM MHBG

Criterion 1

Question 1
(Attachment A, MT Community Behavioral Health Table).
Describe your State's case management services.

TCM services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

The SDMI 1915(c) Waiver CMTs enroll members in the SDMI 1915(c) Waiver and provide case management services. CMTs work within the communities to identify potential providers of state plan and waiver services appropriate to meet the needs of waiver enrolled members. The enrolled members select their providers of their waiver services. Providers who want to provide case management services must meet the qualifications required to provide case management services and must not have any conflict of interest in providing services. The CMTs do not provide any other services except case management. Waiver members can choose their case managers regardless of the team. This choice is documented in each file. CPOs work within the communities to identify potential providers of waiver services appropriate to meet the needs of members in the waiver. Other protections include: every other year face to face waiver member satisfaction surveys, the freedom of choice documentation, and all providers have policies outlining the corporate/dispute resolution procedure.

Describe activities intended to reduce hospitalizations and hospital stays.

Admission to MSH is a judicial process, and the professional staff at the facility do not conduct a pre-admission review or exercise any decision-making authority over the medical necessity for admission. The hospital is licensed for 189 beds.

MT’s SDMI 1915(c) Waiver permits the State to furnish an array of home and community based services which assist individuals who meets institutional level of care to live in the community.

CLOs assists patients committed to MSH to discharge successfully into the community. They provide assistance in accessing needed services, supports, and resources in the community, and provide community support for meeting the recommendations of MSH discharge plan and re-integrating into the community.

Criterion 2: Mental Health System Data Epidemiology (page 8)
Go to Planning Step 1, Criterion 2: Mental Health System Epidemiology on page 8

Criterion 3: Children’s Services (page 10)
Question 1
Go to Statutory Criterion 1.pdf Please contact Mindi Askelson @ MAaskelson@mt.gov For PDF docs

Please describe as needed (for example, best practices, service needs, concerns, etc)
Go to Planning Step 1, Criterion 3: Children’s Services on page 10

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults (page 16)
Describe your State's targeted services to rural and homeless populations and to older adults.
Go to Planning Step 1, Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults on page 16

Criterion 5 Management Systems
Go to Planning Step 1, Criterion 5: Management System on page 18
QUALITY IMPROVEMENT PLAN

Has your State modified its CQI plan from FFY 2016-FFY 2017?
No

MT has not based their administrative operations and service delivery on principals of a Continuous Quality Improvement/Total Quality Management (CQI/TQM) Plan for the FY 2017/2018 Block Grant Application. A CQI/TQM Plan will not be submitted for the FY 2017/2018 Block Grant Application.

While the DPHHS’s does not have a CQI plan, there are several mechanisms in place that review programs for adherence to establish minimum standards. The QAD is the regulatory Division of DPHHS whose mission is to, “Promote and protect the health, safety, and well-being of people in MT by providing responsive, independent assessment and monitoring of human services, through respectful relationships.” The services provided by the Division are licensure, investigating abuse and fraud, recovering overpayment, and performing Federally mandated quality-control reviews.

Medicaid
The Program Compliance Bureau is part of the QAD encompasses 4 units:
- Program Integrity unit which investigates allegations of intentional fraud of recipient eligibility in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, and Low-Income Energy Assistance Program (LIEAP).
- Quality Control unit conducts Federally mandated random reviews of eligibility in the SNAP and Medicaid programs. These reviews are conducted to provide information on the accuracy of eligibility determinations. The results of these reviews are used as a basis to reduce or eliminate the causes of incorrect payments.
- Surveillance and Utilization Review unit is responsible for protecting the integrity of the MT Medicaid Program from Provider fraud, waste, and abuse.
- Third Party Liability unit manages estate recovery, Medicare buy-in, casualty recovery, Health Insurance Premium Payments (HIPP), and the collection of benefit over-issuance.

Legislative review and oversight is a branch of State Government that conducts any legal review or fiscal analysis that it considers necessary.

Contracts
AMDD reviews all contracts with service providers yearly as well as providing monthly program and fiscal updates.

State's targeted services to rural and homeless populations and to older adults.
Go to Planning Step 1, Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults (Page 16)

Criterion 5 Management Systems
Go to Planning Step 1, Criterion 5: Management Systems (Page 18)
TRAUMA

Does the State have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?
No

Does the State provide information on trauma-specific assessment tools and interventions for behavioral health providers?
No

Does the State have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?
No

However, in 2011 DPHHS completed a statewide telephone survey of MT residents which was reported in BRFSS. The results of that survey are reported in (Attachment F, Behavioral Risk Factor Surveillance System Facts, Issue 1 2013). Please contact Mindi Askelson @ MAskelson@mt.gov For Attachment.

In 2014, DPHHS began its efforts to have all staff become Adverse Childhood Experience (ACEs) trained. As part of onboarding, all new staff members watch an online presentation of ACEs. In addition, new staff members attend an in-person training session within 3 months of employment. Currently we are moving towards adopting Trauma-Informed/Trauma Sensitive Approaches agency wide. Each division in DPHHS has an ACEs facilitator to do training within the division. DPHHS has left it up to the divisions as to what training is offered and how to utilize the trainer.

Does the State encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
No
CRIMINAL AND JUVENILE JUSTICE

Question 1
Yes
(Attachment H, County Matching Memo)
(Attachment I, Crime Control Biennial Report)

Crisis Intervention Services include the 72-Hour Program for presumptive eligibility for non-Medicaid, 14 Day Crisis Intervention Program, County and Tribal Matching Grants for crisis intervention and jail diversion, secure crisis beds, and local CIR programs for law enforcement. These programs provide an alternative to placement at the MSH for short-term crisis intervention and emergency detention. Enabling individuals to access crisis services closer to home allows them to use the natural support of friends, family, employers, and community to more quickly return to a place of stability.

In terms of reentry, MCA 53-21-1206 states in (1)(c) that an individual admitted as an inpatient to a mental health facility must have a discharge plan prior to discharge. This provides the necessary provisions to ensure has a plan for re-entry, which address the individual’s mental health needs.

Question 2

The Montana Board of Crime Control (MBCC) is the single state agency dedicated to promoting public safety, crime prevention, and victim assistance. It is governed by a board of directors consisting of a broad range of public and private professionals who have expertise in our justice system. For more than 40 years, the board has provided leadership and financial assistance in support of comprehensive statewide planning to reform and improve the justice system.

In 2013 the MBCC was awarded the Justice and Mental Health Collaboration Grant (JMHCG) to create a consistent, statewide standard of treatment and response in MT’s detention facilities. As such, the MBCC created a strategic plan which has 4 goals to focus the MBCC vision of creating safer communities. This includes reducing the number of individuals with mental and/or SUD problems in jails and emergency rooms. These strategies are:

- Criminal Justice and Behavioral Health information sharing is seamless across the entire justice continuum;
- Evidence based crime prevention initiatives are launched throughout the state to reduce crimes against persons, property and society;
- Services for victims of crime are accessible and are delivered through trauma informed programs and services to help victims heal and reduce future victimization; and
- Early intervention, jail diversion and restorative justice initiatives are launched in communities across MT to reduce incarceration rates and provide opportunities for justice reinvestment.

In 2016, the MBCC was again awarded the JMHCG to further their goals and expand the services provided by crisis intervention teams with an emphasis on improving the response to incidents involving individuals with mental disorders/SUD. This grant project also brings “…together other complementary State projects to further support this endeavor: the Offender Management Information System (OMIS), a case management tool utilized by the Department of Corrections; the mental health screening and suicide risk assessment tool being implemented by AMDD; and the data tracking tool developed in law enforcement Records Management Systems to identify mental health-related calls at time of dispatch.”

(Attachment I, Crime Control Biennial Report)
Question 3

- The MBCC sponsors an annual MT Crime Prevention Conference, which provides cross training for behavioral health professionals and criminal/ juvenile justice personnel.
- Mental Health First Aid is an adult public education program designed to improve individuals’ knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing 1 or more acute mental health crises or are in the early stages of 1 or more chronic mental health problems. These trainings are held around the State and are free of charge.
- Juvenile Parole Officers use the evidence-based program Effective Practices in Community Supervision (EPICS) and case planning based on the Ohio Youth Assessment System (OYAS) to support, monitor and encourage youth to maintain a changed lifestyle of avoiding drug use and illegal behavior.
- CIT MT is an umbrella group that coordinates CIT training and development across the state. CIT programs are local initiatives built on strong partnerships between law enforcement, mental health providers, and individuals and families affected by mental illness. The CIT system attempts to divert mentally-ill individuals from the MSH and the criminal justice system when possible and safe, and instead connect them to appropriate local mental health services that allow them to stay in their communities.

Question 4

The Youth Justice Advisory Council is a cross section of public and private entities who are working to prevent or reduce juvenile delinquency and improve the juvenile justice system.

<table>
<thead>
<tr>
<th>Board &amp; Youth Justice Advisory Council members representing stakeholders in Montana</th>
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<tbody>
<tr>
<td>Attorney General</td>
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<tr>
<td>Criminal Justice Agency</td>
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<tr>
<td>Addressing Youth Violence</td>
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MBCC was created in 1968 as a planning and research agency under the authority of 2-15-2006 MCA whose goal was and still is to promote public safety. The MBCC is an 18-member quasi-judicial board appointed by the Governor. MBCC provides financial support, technical assistance, and supportive services to State and local criminal justice agencies. The board provides funding to local, regional, and statewide projects with the central goal of making MT a safer State. The mission of MBCC is to proactively contribute to public safety, crime prevention, and victim assistance through planning, policy development, and coordination of the justice system in partnership with citizens, government and communities.

The SOC was established by statute in 1993 pursuant to Title 52, Chapter 2, part 3, MCA, to develop an integrated service system for youth under age 18 who are SED, at risk for placement in an out-of-home setting, and needing the assistance of more than 1 State agency. The statute was updated in 2001 to further describe a SOC and to define the duties of the planning committee.
The MT Youth Court Act, implemented by Title 41, Chapter 5, Part 1, MCA, provides for the Cost Containment Review Panel to advise the office of court administrator in administering the cost containment pool and youth court intervention and prevention account. The funds approved by this panel serves, in part, to provide mental health treatment to youth in the correctional system.

**MEDICATION ASSISTED TREATMENT**

**Question 1**

AMDD received a State Targeted Response to Opioid Crisis Grant in May of 2017. Programming associated with this grant will begin in October of 2017. While we have no formal education program currently in operation, the grant activities will address education and awareness within the special target audience.

**Question 2**

AMDD received a State Targeted Response to Opioid Crisis Grant in May of 2017. Programming associated with this grant will begin in October of 2017. While we have no formal education program currently in operation, the grant activities will address education and awareness within the special target audience.

**Question 3**

Go to Medication Assisted Treatment.pdf Please contact Mindi Askelson at MAskelson@mt.gov for a copy of PDF

**Question 4**

AMDD received a State Targeted Response to Opioid Crisis Grant in May of 2017. Programming associated with this grant will begin in October of 2017. While we have no formal education program currently in operation, the grant activities will address education and awareness within the special target audience.

MT House Bill 333 and 323 were passed in April of 2017 addressing the use of Naloxone. We are in the process of writing the rules to govern Naloxone’s use and distribution. We anticipate the rule writing process (including public comment) to be completed by January 2018.
CRISIS SERVICES

Crisis Prevention and Early Intervention

Go to Crisis Services.pdf

Crisis Intervention/Stabilization

Go to Crisis Services.pdf

Post Crisis Intervention/Support

Go to Crisis Services.pdf

Please contact Mindi Askelson at MAskelson@mt.gov for a copy of PDF
MT Senate Bill 62 was passed in April of 2017, addressing the peer support certification. The Board of Behavioral Health is in the process of writing the rules to govern peer support certification. We anticipate the rule writing process (including public comment) to be completed by November 2017.

Question 2

Yes. AMDD’s CDB provides a snapshot of substance abuse in MT as a whole and by county. For additional details (Attachment J, MT Prevention Needs Assessment). Please contact Mindi Askelson at MAskelson@mt.gov for a copy of Attachment

Question 3

The SDMI 1915(c) Waiver integrates recovery support for individuals with SDMI. (Attachment K, SDMI HCBS 002 Introduction and Attachment L, SDMI HCBS 103 Program Goal).

SYT-I is a 3-year SAMHSA funded grant that runs from 9/29/2015 to 9/29/2018. The grant addresses the critical need for providing evidence-based care to adolescents and transitional age youth with SUD and co-occurring disorders by improving the infrastructure for, and access to, treatment and recovery services. All efforts are overseen by an interagency council that includes State agencies, family, and youth members.

EPIC is a partnership between Billings Clinic, a nonprofit integrated health system located in Billings, South Central MT Regional Mental Health Center, and NAMI MT. They have chosen to use Yale’s STEP model for treatment of FEP. The STEP model is designed upon the evidence based model NAVIAGATE. NAVIGATE is the program developed with support from the NIMH based upon their Recovery After an Initial Schizophrenia Episode, or RAISE project, and is 1 of the options for implementation of FEP as described by SAMHSA.

Question 4

The CDB administers the Substance Abuse Prevention and Treatment Block Grant, a SOC designed for individuals who are not eligible for Medicaid or other funding sources and have a family income that does not exceed 200% of the Federal Poverty Level. In order to serve those individuals most in need of SUD treatment and prevention services, a framework provided through our State Approved Chemical Dependency Centers deliver and assure effective and efficient use of our resources. This framework requires a responsive behavioral and physical health service system that focuses on meeting the needs of individuals and families seeking care by ensuring a continuum of services are accessible when needed most. To be effective and responsive, the recovery-oriented system is required to be infused with the language, culture, and spirit of sustainable recovery throughout the care provided to individuals. This assures services focus on engaging and holistic individualized integrated care that produces sustainable recovery outcomes.
IMPLEMENTATION OF OLMSTEAD ACT

Question 1

Question 2
Yes, the MSH Policy and Procedure for Discharge Planning (Attachment M, MSH Discharge Planning). In addition, the State also has the following programs that are designed to keep individuals with SMI in their homes and communities:

- CLOs provide reintegration support services to individuals who have been discharged from the MSH and to individuals who have received crisis stabilization services. These duties require the CLOs have expert knowledge of community and natural supports and how to effectively access them in the transition process; ability to facilitate individuals’ development of personal goals; and skill to facilitate consumer involvement in community activities and supports that lead to independent living, reduced hospitalization, and recovery;
- MT will use Block Grant funds to start a TSP. The purpose of the TSP is to provide 60 days of post-discharge support for individuals leaving MSH. TSP is intended to be the bridge between intensive care and support received at MSH and a successful warm handoff to the community;
- The Goal 189 Program was established to facilitate a more timely discharge for individuals at MSH by creating opportunities and resources for integration back to their community and also to divert individuals from being re-admitted to MSH;
- ICBR was created to decrease the census at the MSH. Medically necessary intensive rehabilitation services are provided in an adult mental health group home to assist the Medicaid member to live outside an institutional setting;
- PACT is a multi-disciplinary, self-contained clinical team approach providing long-term intensive care and all mental health services in natural community settings to Medicaid members. Interventions focus on achieving maximum reduction of physical and mental disability and restoration of the member’s best possible functional level. The treatment model goal is to decrease the frequency and/or duration of hospitalizations, crisis services, and/or incarceration; and
- MT PATH Program provides services for individuals being discharged MSH into homelessness. The MT PATH Program can assist with service stability for those individuals.

Question 3
None at this time.
CHILDREN AND ADOLESCENTS

Question 1 – Go to Children and Adolescents.pdf
Go to Planning Step 1, Criterion 3, Children’s Services (Page 10)

Question 2 – Go to Children and Adolescents.pdf
Go to Planning Step 1, Criterion 3, Children’s Services (Page 10)

Question 3 – Go to Children and Adolescents.pdf
Go to Planning Step 1, Criterion 3, Children’s Services (Page 10)

Question 4 – Go to Children and Adolescents.pdf
Go to Planning Step 1, Criterion 3, Children’s Services (Page 10)

Question 5 – Go to Children and Adolescents.pdf
Go to Planning Step 1, Criterion 3, Children’s Services (Page 10)

Youth in Foster Care

The Montana Foster Care Independence Program (MCFCIP) is a part of the CFSD. The services offered by the MCFCIP are intended to help MT foster youth get the life skills they need to make a successful transition into adulthood. By assisting youth in achieving self-sufficiency and obtaining future goals, the MCFCIP enables youth in the foster care system create a healthy lifestyle and a successful future.

Services offered:
- Life skills instruction;
- Educational/Vocational Assistance;
- Transitional living plans;
- Life skills assessments;
- Mentors; and
- Youth Advisory Board.

Assistance with:
- Obtaining a graduation equivalency degree, or HiSet;
- Obtaining a high school diploma;
- Accomplish other educational achievements;
- Acquiring volunteer experience;
- Satisfactory school performance;
- Enrolling in life skills groups;
- Enrolling in other activities intended to increase life skills and employability; and
- Obtaining full- or part-time employment.
Stipends available for youth ages 14 to 21 whose transitional living plans indicate they need help paying for:

- Secondary school educational expenses, such as tuition, tutoring, books, or driver’s education;
- Vocational training, including apprenticeships;
- Job readiness assistance, such as preparing a resume, buying appropriate interview clothing, haircuts, etc.;
- Travel costs to school or job sites; and
- Setting up a dormitory room or apartment, including purchase of furniture, kitchen supplies, deposits, etc.

Describe how the State provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, SUDs, etc.)

Go to Planning Step 1, Criterion 3, Children’s Services (Page 10)
SUICIDE PREVENTION

Question 1
Yes
(Attachment D, MT Strategic Suicide Prevention Plan)

Question 2
(Attachment D, MT Strategic Suicide Prevention Plan)
(Attachment C, MT Native Youth Suicide Reduction Strategic Plan)

Prevention
- Address the stigma associated with mental illness and asking for help;
- Increase awareness of youth suicide prevention and focus on coping/resiliency skill development at the elementary and middle school level;
- Develop community provider networks;
- Increase training for law enforcement agencies and health care professionals;
- Conduct gatekeeper trainings;
- Provide depression screening programs in schools and health care;
- Implement evidenced-based curriculum into MT’s schools (Mental Health First Aid);
- Continue with an aggressive media campaign that increases awareness of warning signs, how to intervene, and resources; and
- Pilot promising interventions and programs.

Intervention
- Increase access to mental health and substance abuse services including smoking cessation programs;
- Develop and implement clinical screening programs and standard screening tools with appropriate referral and follow-up; and
- Increase the number and ability to access crisis stabilization beds.

Coordination
- Improve communication and community linkages with mental health and substance abuse service systems serving youth and young adults.
- Demonstrate collaboration between State, local, and tribal communities.

Question 3
Yes

Question 4
Yes

Question 5
Yes
(Attachment C, MT Native Youth Suicide Reduction Strategic Plan)
PARTNERSHIPS

**Question 1**
No

**Question 2**
Yes

Affordable housing is a major issue for all Montanans, but is especially difficult for individuals with an SMI. As part of this year’s MT PATH Program RFP, providers were scored on their ability to develop, maintain, or enhance partnerships with landlords, local and State housing authorities, property managers, Department of Commerce, CoC agencies, as well as faith based and non-faith based shelters.

**Question 3**

MT currently benefits from strategic partnerships with other health, social services, and education providers, as well as other State, local, and Tribal Governmental entities.

DPHHS has successfully negotiated government-to-government Master Agreements for all health care dollars passing between the DPHHS and MT’s tribes. It covers reoccurring negotiation issues such as sovereign immunity, insurance, government-to-government respect, court of competent jurisdiction, among others, so these items do not have to be negotiated every time a contract expires. The Master Agreements were signed for a ten (10) year period, with clauses for amendments if agreed upon. With this overarching Master Agreement, all subsequent contracts will now be designated as “task orders” and fall under the Master Agreement with each Tribal Government.
STATE BEHAVIORAL HEALTH PLANNING/ADVISORY COUNCIL AND INPUT ON THE MENTAL HEALTH BLOCK GRANT APPLICATION

Question 1
The MT MHOAC participates in review of requirements for the Block Grant Plan and approves the major components of the Plan before submission. An opportunity to provide public comment is incorporated into the Council’s standing agenda. (Attachment Q, MHOAC Minutes 10.19.16, Attachment R, MOHAC Minutes 2.3.17, and Attachment S, MHOAC Agenda 7.29.17) Please contact Mindy Askelson @ MAskelson@mt.gov for a copy of these Attachments.

Question 1 (a)

The statewide philosophy for delivery of SUD treatment and prevention services must be sensitive to situations unique to MT. While MT ranks 4th in geographical area (145,388 square miles), it ranks 38th among States in population. The racial distribution of the State is 93% white, with the remainder being predominately Native American.

In accord with 53-24-211 MCA, local planning for SUD treatment and prevention services is the responsibility of each county's board of commissioners. County plans are developed every 4 years with an annual action strategy update. County plan guidelines are provided by the DPHHS and a standardized format is used by each county. Data assembled by the State State Epidemiological and Outcomes Workgroup (SEOW) and State staff is assembled and presented as part of this packed of information. The data provides outlines of incidence, prevalence and greatest need at each county level. The guidelines also allow for development of multi-county plans. County plans include the following sections:

- County Data Presenting, Incidence, Prevalence, Need, and Usage of Services
- Documentation of County Collaboration
- County Identification/Action Forms
- Description of Service Area and County Planning Process
- Analysis of County Needs
- Primary Prevention Services
- Early Intervention and Treatment Services

County plans provide the DPHHS with uniform planning information, local needs and priorities and solutions to local service delivery problems. As part of the planning process, counties must determine special population needs including Native Americans, pregnant women and women with dependent children, SSI recipients, HIV/AIDS, youth, and repeat DUI offenders. County alcohol tax monies are allocated as part of each year's county plan update subject to approval by the DPHHS. As part of the county planning process, public meetings must be held as part of the county commissioners meeting. This information must be presented in the packets. This occurs each April or May of each year.

Question 1 (b)
The CDB and the MHSB are working in several areas to integrate work. The CDB Bureau Chief presents information at the advisory council for information and input. Staff, from both the CDB and the MHSB, are located in the same building, work under the same administrator, and continue to work together in multiple projects and services to address those in need.

The Council has consistently included a representative with SUD treatment expertise. Representatives from AMDD’s CDB attend and actively participate in all Council meetings.

Question 2
Yes
**Question 3**

Although the focus of the Council is Mental Health, SUD treatment and prevention issues are presented to this committee and will continue to do so until State law can be changed to formally recognize the inclusion of SUD treatment and prevention as part of a behavioral health system.

The MHOAC’s mission is:
We are partners in planning and oversight for a mental health system that effectively serves families and individuals throughout MT.

The Council’s vision is: We envision a collaborative public mental health system that promotes independence, self-determination, stability in families and recovery. The system will provide effective community-based treatment, and ability to participate in educational opportunities, meaningful work, satisfying family relationships, and personal friendships.

The Council’s purpose is:
The 1999 Legislature created this council to provide guidance and oversight to the DPHHS in the development and management of an effective public mental health system.

The duties of the Council are to:
- Review the Mental Health Block Grant Plan and to make recommendations to the DPHHS;
- Serve as an advocate for adults with a SMI, children with a SED, co-occurring disorders, and other individuals with mental illnesses; and
- Monitor, review, and evaluate the allocation and adequacy of mental health services within the State.
<table>
<thead>
<tr>
<th><strong>WAIVERS</strong></th>
<th><strong>Diversion from MSH</strong></th>
<th><strong>Prevention</strong></th>
<th><strong>Early ID</strong></th>
<th><strong>Treatment</strong></th>
<th><strong>Recovery</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severe Disabling Mental Illness (SDMI) 1915c Waiver</strong></td>
<td>A recovery-oriented mental health service delivery model designed to keep individuals in the community and out of a higher level of care</td>
<td></td>
<td>X</td>
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<table>
<thead>
<tr>
<th><strong>STATE FUNDED PROGRAMS</strong></th>
<th><strong>Diversion from MSH</strong></th>
<th><strong>Prevention</strong></th>
<th><strong>Early ID</strong></th>
<th><strong>Treatment</strong></th>
<th><strong>Recovery</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crisis Stabilization Treatment Beds</strong></td>
<td>Secured crisis stabilization services for individuals admitted for inpatient crisis intervention services needed prior to an involuntary commitment petition being filed or emergency detention or court-ordered detention after an involuntary commitment petition has been filed but before final disposition</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Goal 189</strong></td>
<td>A State fund program established to facilitate a more timely discharge of individuals from Montana State Hospital (MSH) by creating opportunities and leveraging resources for integration into the community and to divert admissions to the MSH</td>
<td></td>
<td>X</td>
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<tr>
<td><strong>1115 Waiver for Additional</strong></td>
<td>Provides Standard Medicaid for</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Services and Population (WASP)</td>
<td>members with a SDMI who are over income for Medicaid; or Medicare eligible and ineligible for Medicaid</td>
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<tr>
<td>72 Hour Program</td>
<td>Provides State funds to help with costs of evaluation and stabilization for up to 72 hours for individuals in crisis who are not eligible for Medicaid</td>
<td>X</td>
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<td>X</td>
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</tr>
<tr>
<td>County and Tribal Matching Grant Program</td>
<td>Provides State funds to communities and tribes to develop a strategic plan to address crisis intervention and diversion from MSH. Counties that include tribal lands must demonstrate coordination efforts with tribal representatives both on and off reservations</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Drop In Centers</td>
<td>Peer-oriented, community based programs provides a safe, friendly, confidential, supportive atmosphere for individuals to share experiences without fear of judgement</td>
<td></td>
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</tr>
<tr>
<td>Short-Term Voluntary Inpatient Crisis Stabilization (14 Day Diversion)</td>
<td>Intended to divert individuals from commitment to the Montana State Hospital and other mental health facilities by providing reimbursement to programs that can serve individuals in a short-term voluntary inpatient setting not to exceed 14 days</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>MEDICAID MENTAL HEALTH CENTER SERVICES</td>
<td>Diversion from MSH</td>
<td>Prevention</td>
<td>Early ID</td>
<td>Treatment</td>
<td>Recovery</td>
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<tr>
<td>Mental Health Group Homes</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Adult Foster Care</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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<td>Day Treatment (DayTx)</td>
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<tr>
<td>Illness Management and Recovery (IMR)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Crisis Intervention Facility</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Program for Assertive Community Treatment</td>
<td>divert from inpatient hospitalization</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Intensive Community Base Rehabilitation</td>
<td>Group homes focused on rehabilitation and recovery</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Targeted Case Management (TCM)</td>
<td>Assistance in gaining and coordinating access to necessary medical, social, and educational care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Acute Partial Hospitalization</td>
<td>At least 20 hours of therapy per week to improve functioning in the home, school, and community settings</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Dialectical Behavior Therapy Services (DBT)</td>
<td>A comprehensive, cognitive-behavioral treatment for individuals with SMI</td>
<td>X</td>
<td>X</td>
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<tr>
<th>BLOCK GRANT</th>
<th>Diversion from MSH</th>
<th>Prevention</th>
<th>Early ID</th>
<th>Treatment</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Employment</td>
<td>Helps youth with SEDs and adults with SMI work in a competitive job environment of their choosing</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>First Episode Psychosis (FEP)</td>
<td>Provides a wide range of intensive services to youth and young adults suffering from their first psychotic episode</td>
<td></td>
<td>X</td>
<td>X</td>
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</tbody>
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<table>
<thead>
<tr>
<th>FACILITIES</th>
<th>Diversion from MSH</th>
<th>Prevention</th>
<th>Early ID</th>
<th>Treatment</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCDC</td>
<td>State in-patient addictions, co-occurring addictions and psychiatric</td>
<td></td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>MMHNCC</td>
<td>Residential facility for long term treatment of persons who have a mental disorder and require a level of care not available in the community</td>
<td>X</td>
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<tr>
<td>MSH</td>
<td>State operated inpatient psychiatric hospital</td>
<td>X</td>
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</table>

**TRAININGS**

<table>
<thead>
<tr>
<th>Mental Health First Aid</th>
<th>A national program to teach the skills to respond to the signs of mental illness and substance use</th>
<th>Early ID</th>
<th>Treatment</th>
<th>Recovery</th>
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<td></td>
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<thead>
<tr>
<th>Crisis Intervention Response (CIR)</th>
<th>A 40 hour training for first responders and emergency health service providers that includes post-traumatic stress disorder, traumatic brain injury and suicide assessment</th>
<th>Early ID</th>
<th>Treatment</th>
<th>Recovery</th>
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<td></td>
<td>X</td>
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</table>

**PROGRAMS**

<table>
<thead>
<tr>
<th>SSI/SSDI Outreach, Access and Recovery (SOAR)</th>
<th>A national program designed to increase access to the disability income benefits program</th>
<th>Early ID</th>
<th>Treatment</th>
<th>Recovery</th>
</tr>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Projects for Assistance in Transition from Homelessness (PATH)</th>
<th>Providing outreach for those who are experiencing persistent mental illness and homelessness to access mainstream public mental health services</th>
<th>Early ID</th>
<th>Treatment</th>
<th>Recovery</th>
</tr>
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<tr>
<td></td>
<td>X</td>
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</table>
9:11am Bill Hodges calls meeting to order (Chris Bates will not be able to attend today)

Introductions

No Quorum for Minute Approval or Block Grant approval (may need to do approval of the grant telephonically)

Mindi – Expectations of the Council - SEE Handouts “Boards, Councils and Commissions” and “Guidance for Members Appointed to Advisory Councils…”

- This Board is not actually a boards, actually an Advisory Council (to DHPPS),
- We are one of 7 Advisory Councils within DHPPS,
- Minutes from last meeting indicated that the Council wanting more interaction with other Advisory Councils that work with similar clients, if we see groups that we want information from we can narrow that down and invite them to attend/share with us,
- MHOAC is mandated by federal and state law for agencies receiving Block Grant funds
- The Council cannot advocate a position, but individuals on the council can advocate as an individual and make recommendations to AMDD,
- SEE Handout “MHOAC Meeting 10/19/2016”, Every item on the agenda is an item on the handout, listed some things the Board may want to take action on (ways to take action),
- Notes handout is where Mindi wants to see advice or recommendations,
- Collect handout at end of meeting please put names on if feel comfortable, asking for Board indulgence to fill out, Bill suggests that Exec Council will review the notes on handouts and use them to form the next Council Meeting.

Department Updates

- Glenda Oldencamp
  - FINAL MHOAC UPDATE
  - County Matching Grants 2.1M to award, more ask than money for the first time this year in FY16
    - Crisis Intervention and Jail Diversion,
    - MH Services in Jail, CIT Team Training,
- CRT, expansion of Crisis Beds in Eastern MT,
- Secure Crisis beds in Missoula
  - Crisis Facilities: 264 clients served in ED/Secure Crisis Beds
    - 96 to MSH,
    - 11 to local hospital
    - 66 to Voluntary Crisis Beds,
    - Rest to Community Services,
    - Short Term In Patient beds are contracting with Crisis Facilities, to provide the option of voluntary stay in community to avoid involuntary commitment to MSH
- Zoe Barnard
  - Currently using federal Block Grant dollars to fund essential community services,
  - MHSP funds now only being used for narrow window of individuals that have no other funding source (gap with Medicaid eligibility),
  - There will now be some money to do some activities prevention and an ideal Continuum of Care – but Zoe is interested in here what other ideas are out there. Some ideas suggested were Peer Services, Online CBT, support, supported web based interaction between primary care doctors and psychiatrists,
  - First Episode Psychosis - NIMH research shows that if you get to people at first episode can ameliorate symptoms over a lifetime (RFP attached).
    - SAMHSA mandated that 10% of Block Grant dollars be put toward this.
    - We are working with NAMI to implement this program and the RFP is currently open.
    - The grant is 263K and must include the use of NAVIGATE program developed by NIMH and staff the program with a Program Director, Prescriber, Individual Resiliency Trainer, Supported EM Specialist, and a Case Manager. Grant award will be announced by Nov 15.
  - Bill discussed how the Council could share this information with other stakeholders and how to become more involved.
- Rebecca de Camara
  - Introduced the new Children’s Mental Health Bureau Chief Eric Higginbothom.
  - Native American Youth Suicide Prevention Grant is legislation funded by Gov. Bullock to address disproportionate number of Native American youth who attempt suicide, first coalition meeting held Nov 2 and 3 in Helena, 26 representatives of all tribes and urban Indian Centers, as well as youth were represented.
  - Youth Crisis Diversion Contracts, HB 47 released an RFP for 1.2M to fund community wide Chemical Dependency Projects in Missoula, Billings, Helena. The RFP allows different communities to design best program for their community, variety of different projects. Some nationally fund projects that are successful include an interactive crisis response website as well as designation of community based crisis beds.
  - MT CoOccurring Capacity Building Grant 2.8M SAMHSA Grant, increase availability of clinical providers who can address MH and SUDS, resulting in misdiagnosis and mistreatment in only treating one component, grant activities = workforce training, mapping expenditures, integration of co-occurring model in Billings, Helena, Missoula has led to a transitional grant with youth and treating across youth to adult systems, this is the Behavioral Health Home Pilot.
 Closure of MDC – Legislated to take place by July of 2017, 29 successful community placements, more successful than Rebecca anticipated. Clients placed with new group home provider, Benchmark is going well. There are 25 remaining clients to place, 12 of which are in the Secure Assessment unit and are extremely hard to place. Rebecca is hoping that the Legislature will allow MDC to stay open until these clients are placed. To prepare communities for these clients, awareness training has been provided to law enforcement and first responder disability awareness training.

 Andy Hunthausen asked who does the Council make a recommendation to regarding MDC, specifically what happens if the remaining clients can’t be placed,

 Carolyn stated that she had heard that things have gone smoothly regarding the goals of SB411. However, some legislators are suggestion to extend the date of the closure as the remaining clients are difficult to place. There are a number of programs that would help with these placements but the state does not have those specific programs in place. Additionally we need more time to get ancillary services in place, keep the transitions going smoothly.

 The next transition Committee meeting is in Dec. At the last meeting the need for a crisis response program in Eastern and Western MT was discussed.

 Sydney Blair discussed the Health Home or Crisis Diversion Grant. She was disappointed with Interim Committee and how the information was presented. In 3 months of operation Great Falls has deterred 9 clients from higher level of care would have resulted in larger savings than total cost of grant. A crisis transition house was opened in Sydney, and provides placement, full assessment, and rapid turnaround to see a provider, respite for family and referral to other services. Health Home Project working with 3 agencies to figure out how to do integrated care, same consultant across state, focus is young adult 16 to 25.

 Carolyn Pease-Lopez – She acknowledges that Legislator is big on not funding mandates such as the closing of MCD. There are some legislators who are unofficially voicing concern that timeline was very ambitious, specifically for clients who have not yet been transitions. They now realize that communities are not prepared to take on these clients and they are planning on readdress positively in next session. She also explained how bills are put forth to the Legislature/
• SAA Updates: No one from the SAAs were present however, Antonia reported that All SAAs needed representative. Mindi also shared that she was working on a plan with Carrie to improve the communications flow between the LACs, SAAs and MHOAC.

• Mindi shared an update on Supported Employment Statistics, which is attached.

• Board of Visitors – Dan Ladd introduced himself as the new Executive Director of the Board of Visitors. He explained his role and the fact that the Board is an independent entity that serves as oversight MDC and MSH. The Board reports directly to the governor’s office. Dan also expressed hope that the Board, Council, LACs and SAAs move towards working together, especially at the community level. The Board is also recruiting members from Eastern Montana.

• The question was asked how we can address issues and concerns that pop up while the Legislature is in progress. We want to make sure that we respond with a coordinated voice. Carolyn invited individuals to contact her with new information. Additionally, Mindi and Carrie will have access to daily legislative updates that they can share.

• Karl Rosston – Suicide Mortality Review Team Update (presentation attached)

• Renae Huffman, Theresa Stahly, Rebecca Corbett – Medicaid Expansion (presentation attached)

• Bobbi Perkins – Attended Block Grant Conference in August. MT will be having a Monitoring Visit this spring and it will focus on primary prevention.
  - Substance Abuse Block Grant also needs to form an Advisory Council like MHOAC. There was a discussion about they should form their own Council or combine with MHOAC or the Children’s System of Care Committee. The issue was tabled for a later date.
  - 20% of Block Grants for primary prevention programs.
  - Contractors have not been able to spend all of contracts now that Medicaid is covering more treatment. The Bureau has a list of priorities that they will use for the excess funds.
  - Behavioral Health Care Act Bill – SUDS Providers are currently required to be state approved for Block Grant contracts and to bill standard Medicaid. However current legislation requires that provider’s meet a non-duplication and local need provision to be approved. Department is working to remove that language to increase the number of providers within the system.
  - MT Healthcare Foundation is contracting with Manat to do an Environmental Assessment of SUDS system, Medicaid benefits, admission standards, payment levels, and methodology.
  - Sydney predicted that some providers will pull out of providing services due to not wanting to compete for Block Grant dollars which will impact rural areas. She also foresees providers’ population splitting into two entities, those that work with children and those who work with adults. How do we get people dually licensed? That question needs to be taken to the Department of Labor and Industry as well as the Social Work Board.
  - The group then discussed the pros and cons of integrated care.

Plan to increase active participation of MHOAC (attached) – MHOAC needs to find a way to motivate Council members.

• Decision on adopting this plan needs to be tabled until a quorum is present. Mindi will attempt to schedule a WebEx meeting.

• A major rewrite on the Block Grant will take place in 2017. Previously 1/3 of funding was for Mental Health Services Plan which is no longer needed due to Medicaid Expansion. Ideas for
using those dollars include: PATH, Supported Employment, PAX Good Behavior Game, Housing vouchers and Native American Suicide Prevention. An email will be sent out in November with recommendations.

Next meeting dates: 2/15/17 (Helena), 05/16/17 (Fairmont – will tour Forensic MH Facility), 10/04/17 (Helena - Board Training), 10/05/17 (Helena).

Meeting was adjourned.