PRESENTATION TO THE 2025 BIENNIUM
LEGISLATIVE INTERIM COMMITTEES

Behavioral Health and Developmental Disabilities Division

Medicaid and Health Services Practice
Department of Public Health and Human Services

THE FOLLOWING TOPICS ARE COVERED IN THIS REPORT:

- **Overview**
- **Summary of Major Functions**
- **Recent Highlights and Accomplishments**

OVERVIEW

The Behavioral Health and Developmental Disabilities Division (BHDD) administers a wide range of services to fulfill its mission of facilitating the efficient delivery of effective services to adults and children with behavioral health challenges and/or developmental disabilities. BHDD's work is guided by a goal of providing Montanans with the support to live full lives within their communities. BHDD consists of four bureaus and two programs.

Rebecca de Camara is the Administrator for BHDD. Prior to this role, she served as the Administrator for the Developmental Services Division for nearly 10 years. Rebecca began her work in the human services field as a behavioral health direct care worker nearly thirty years ago and has worked in a variety of different positions across the behavioral health and developmental disability care continuum. Rebecca has a Bachelor of Arts in Psychology and a Doctor of Jurisprudence from The University of Texas at Austin.

PREVENTION BUREAU

The Prevention Bureau employs Program Officers that manage distinct grants and programs. The Bureau's Program Officers oversee every aspect of their assigned programs, including developing Requests for Proposals, establishing and monitoring contracts, managing budgets, providing technical assistance, and working with internal and external stakeholders to advance programmatic goals. The Bureau also includes a Program Evaluator and two Epidemiologists, which provide data collection support and conduct data analysis to monitor program utilization and outcomes.

Jami Hansen has been the Prevention Bureau Chief since November 2022. Prior to becoming the Prevention Bureau Chief, Jami worked for the Department for three years during which she led efforts to improve the Mental Health Block Grant programs. During her tenure, Jami has focused on increased collaboration with advisory councils and Service Area Authorities. Jami has over ten years of experience working in behavioral health, including the development of Peer Support Services in Washington State.

TREATMENT BUREAU

The Treatment Bureau is comprised of three distinct sections: Medicaid State Plan, Severe and Disabling Mental Illness 1915(c) waiver, and a Special Populations section. Each section has Program Officers who manage distinct Medicaid and Non-Medicaid services and programs. The Bureau's Program Officers oversee every aspect of their assigned programs, including developing Requests for Proposals, establishing and monitoring contracts, completing state plan and waiver amendments, managing budgets, and providing technical assistance. In addition to central office staff, the Bureau has two Community Program Officers who each cover half of the state providing important assistance and support to waiver provider agencies, Case Managers, and members and their families. The Bureau employs a Licensed Addictions Counselor who oversees the state approval process for SUD programs, which works to assure compliance with standards of care.

Isaac Coy has been the Treatment Bureau Chief since November 2022. Isaac has worked for the Department for over nine years. During his time with DPHHS, Isaac has served as a Program Officer and Section Supervisor; working with behavioral health providers and stakeholders to expand the continuum of care to ensure that Montanans have access to needed services. Prior to joining DPHHS, Isaac worked as a Licensed Addictions Counselor (LAC) in a variety of treatment settings including Program of Assertive Community Treatment, SUD outpatient treatment, and SUD residential treatment.

CHILDREN'S MENTAL HEALTH BUREAU

CMHB consists of a Medicaid Program Section and a Clinical Team. The Medicaid program staff oversee operations of the Bureau including benefit plan, administrative rules, appeals, and provider support. The program section is also responsible for the tracking and reporting of outcome measurements. The Bureau's clinical team includes a part-time Board-Certified Child and Adolescent Psychiatrist, Licensed Mental Health Clinicians, and Regional Resources Specialists. The Bureau's clinical team provides care coordination for Medicaid enrolled youth receiving psychiatric residential treatment outside of Montana. Care coordination duties include attendance at treatment team meetings, assistance with discharge planning, monitoring of quality of care, and engagement with parents and caregivers of youth. Regional Resource Specialists provide information and resources on service availability, including community-based therapeutic group homes and community services available by region. Regional Resource Specialists serve parents and caregivers, behavioral health providers, Child and Family Service employees, and other organizations within the children's systems.

Meghan Peel is the Children's Mental Health Bureau (CMHB) Chief for BHDD and has served in this role for over five years. During her tenure with the Bureau, she has focused on working closely with providers and stakeholders to evaluate and improve services within the children's continuum of care, focusing on family engagement and outcome measurements. Prior to joining DPHHS in 2013, Meghan worked in public and private accounting for seven years.

SUICIDE PREVENTION

The Suicide Prevention Program operates out of a central office in Helena. The program includes a Suicide Program Manager and a Grant Manager for the Adult American Indian Zero Suicide Grant. The Suicide Program Manager oversees the implementation of the 988 Crisis Lifeline and works with the Montana VA and National Guard on prevention efforts to reduce the rate of suicide in Montana Veterans. The Grant Manager for the Adult American Indian Zero Suicide Grant helps tribal health and Urban Indian Health Centers establish a suicide care policy promoting suicide safe care as an organizational priority and facilitates training to create a confident and competent workforce where at-risk individuals are identified.

Karl Rosston is the Suicide Prevention Coordinator for the Montana Department of Public Health and Human Services. He provides evidenced-based programs to all Montana secondary schools, implements the State Suicide Prevention Plan, supports the Montana Suicide Prevention Crisis Line, implements firearm safety programs and statewide media campaigns, provides suicide prevention trainings, and coordinates suicide prevention efforts around the state. Karl is adjunct

faculty at the Montana Law Enforcement Academy and a nationally certified trainer in QPR and Mental Health First Aid.

DEVELOPMENTAL DISABILITIES PROGRAM

The Developmental Disabilities Program (DDP) Bureau operates out of a central office in Helena and five regions across the state with offices located in Helena, Missoula, Great Falls, Billings, Glasgow, Miles City, Butte, Bozeman, and Kalispell. The regional offices provide important assistance and support to members and their families receiving or applying for services, DDP provider agencies, and Case Managers. Each region has a Regional Manager who oversees quality assurance activities, incident management activities, and serves as the local liaison with the community. In addition, the regions have Quality Improvement Specialists who work directly with provider agencies and members. Some regions also provide Targeted Case Management services.

Lindsey Carter is the DDP Bureau Chief and has worked for DDP for over nine years. Before taking the Bureau Chief position, Lindsey worked as a DDP Waiver Specialist, Regional Manager and Community Services Supervisor. During her time as Bureau Chief, Lindsey has led efforts to increase engagement with providers and stakeholders with a focus on revising and streamlining policies to increase system efficiencies. Prior to joining the Department, Lindsey held a variety of positions in the developmental disabilities field including Case Manager, Early Intervention Specialist and Direct Service Professional.

OPERATIONS BUREAU

The Operations Bureau operates out of a central office in Helena. The bureau is comprised of 9.75 FTE and provides fiscal, budgetary, and contract support to the division.

Natacha Bird is the Operations Fiscal Bureau Chief for the BHDD. Natacha has a bachelor's degree in accounting and has worked for the State of Montana for 22 years. Prior to joining the department, Natacha worked as the Fiscal Bureau Chief at the Department of Justice for 7 years, and as an accountant for the Commissioner of Securities and Insurance.

SUMMARY OF MAJOR FUNCTIONS

BEHAVIORAL HEALTH CONTINUUM OF CARE

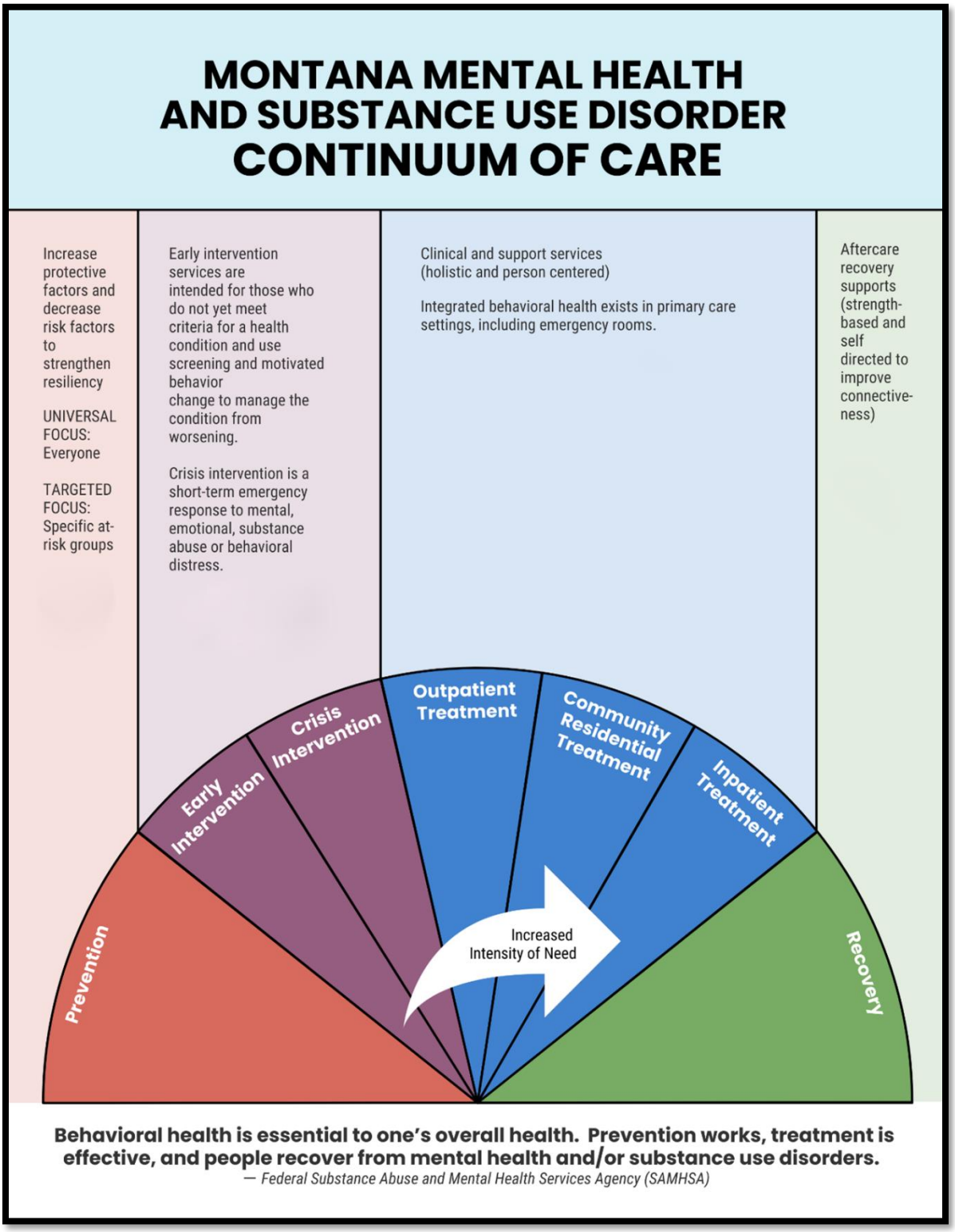

Figure 1 – The Continuum of Care.

PREVENTION SERVICES

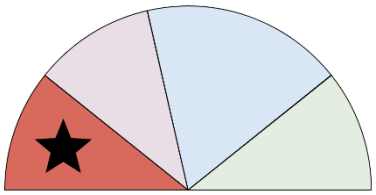

Figure** 2 - **Prevention section of Continuum of Care.

Mental illness and substance abuse affect tens of thousands of Montanans and have a huge impact on the public's health and productivity. Behavioral health conditions are associated with a wide range of health and social problems.
Effective prevention strategies are critical to provide both individuals and communities the skills to develop and promote healthy behaviors that can prevent or delay the negative consequences of behavioral health conditions.
A large body of scientific research supports the implementation of effective prevention programs. If programs are consistently administered to fidelity over time, they have the potential to reduce the number of Montanans impacted by behavioral health issues.

BHDD supports the implementation of community-based behavioral health prevention initiatives across Montana. Community-based prevention promotes public health and coalition-based approaches to enact effective, community-driven prevention strategies. Prevention initiatives include both universal strategies to prevent children and youth from engaging in substance use and targeted interventions to mitigate substance use amongst at-risk populations.

BHDD implements programming that enables communities to have a dedicated Prevention Specialist who leads the community through evidence-based processes, including the completion of a needs assessment, the development of a strategic prevention plan, and the implementation of interventions that meet the community's unique needs and goals. These efforts are bolstered by technical assistance and training offered by BHDD.

Prevention strategies are also implemented via school-based programs and dedicated resources for those in a parenting role. The PAX Good Behavior Game (GBG) is a school-based intervention used to teach self-regulation, self-management, and self-control in children, which has shown evidence of short-term and long-term benefits including improved classroom behavior, academics, and behavioral health and the prevention of substance use and suicide. PAX GBG is currently implemented in 29 school districts and is expanding to new schools every year.

ParentingMontana.org
PARENTING MONTANA
TOOLS FOR YOUR CHILD'S SUCCESS

Along with PAX GBG, BHDD also implements www.ParentingMontana.org, a web-based resource for Montana parents and those in a parenting role. The resources and strategies incorporated within the website are rooted in prevention science and tailored to Montanans. This prevention program braids together the supports grounded in evidence-based practices to help kids and families thrive, with the specific goals of cultivating a positive, healthy culture among Montana parents with an emphasis

on curbing underage drinking; providing resources to engage parents or those in a parenting role; and providing tools for everyday parenting challenges from ages zero to nineteen.

By starting early, both parents and children learn to grow skill such as self-awareness, self-management, responsible decision-making, and social awareness, all of which protect children from negative outcomes associated with adverse childhood experiences (ACEs) and bolster resilience.

Early Intervention services

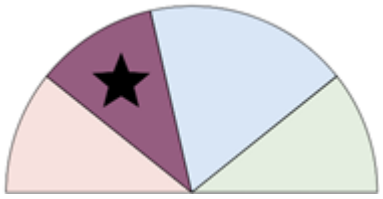

FIGURE 3 - EARLY INTERVENTION SECTION OF CONTINUUM OF CARE.

Early intervention services implement specific practices to target individuals who are at risk of developing an illness. Early intervention services can mitigate the need for individuals to engage in higher levels of care, resulting in less disruption to their lives and improved health outcomes. BHDD facilitates several early intervention programs targeted toward individuals engaging in substance use, including evidence-based education programs for individuals charged with a Driving Under the Influence (DUI) or Minor in Possession (MIP) and a program focused on naloxone, an opioid antagonist that can successfully reverse the effects of an opioid overdose. The naloxone program focuses on increasing awareness of naloxone, providing training on its administration, and distributing units throughout the state. The program facilitates a statewide media campaign and provides training to first responders, Emergency Medical Services (EMS), healthcare providers, community organizations, and members of the public on how to safely and effectively administer naloxone. Training materials, including step by step instructions on administration, are also available on naloxone.mt.gov and are included with every shipment of naloxone. BHDD utilizes federal grant funding to cover the cost of naloxone, so communities and organizations are able to order up to 500 units at a time at no cost. Since October 2021, nearly 29,131 units of naloxone have been distributed throughout Montana.

Figure 4 - Opioid overdoses and naloxone information.

BHDD has recently implemented the Montana Angel Initiative to provide another means of accessing substance use treatment. The initiative allows an individual struggling with addiction to go to any participating law enforcement office and receive assistance in locating and being connected with treatment, without consequences or questions (subject to certain limitations).

The Angel Initiative launched in late 2021 and is currently active in Cascade, Lewis and Clark, and Yellowstone counties. BHDD has partnered with the Police Assisted Addiction and Recovery Initiative (PAARI) to provide training to the participating counties. Over the next year, BHDD and PAARI will expand those trainings to other counties that have committed to participate in the Angel Initiative.

Early intervention services can also mitigate negative outcomes for individuals experiencing behavioral health issues. BHDD supports the implementation of a First Episode Psychosis (FEP) program. FEP is an evidence-based program that facilitates early identification of an initial psychosis episode in youth, young adults, and in the near future, adults up to age 40, early access to wraparound treatment services, and ongoing support services for both the individual and their family. FEP programs are a required set aside within the Mental Health Block Grant as the programs have been shown to be highly effective in reducing or ameliorating adult psychosis. BHDD currently funds two FEP programs at Billings Clinic and Alluvion Health and is actively working to establish one additional program to serve other regions of Montana within the next year.

In October 2022, BHDD expanded a pilot project for universal screening through a contract with Rural Behavioral Health Institute (RBHI). For school year 22/23, RBHI will provide up to 30,500 comprehensive screenings for middle and high school students in Montana. RBHI will implement an evidence-based digital suicide risk screening tool that connects students with elevated risk of suicide to same-day mental health care in middle and high schools across the state. Universal suicide risk screening linked to follow-up mental health care, or Screening Linked to Care (SLTC) increases the proportion of at-risk youth identified and connected with appropriate mental health care. RBHI's digital screening platform includes validated assessments for suicide risk, depression and anxiety symptoms, functioning, and substance/alcohol use.

CRISIS INTERVENTION SERVICES

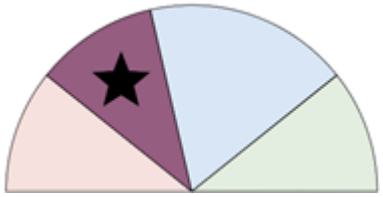

Figure 5 - Crisis intervention section of continuum of care.

Following the 2020 release of the SAMHSA's National Guidelines for Behavioral Health Crisis Care, the BHDD has increasingly focused on Montana's behavioral health crisis system through the dedication of staff resources and the creation of a Crisis System Strategic Plan. The strategic plan establishes goals, objectives, and strategies to improve Montana's crisis system and align Montana's crisis system with the Crisis Now best practice model.

The Crisis Now model has four core components:

- Regional or statewide crisis call centers;
- 24/7 mobile crisis response services;
- Crisis receiving and stabilization programs; and
- Essential principles and practices, including:
    - Trauma-informed care;
    - Use of peer support specialists; and
    - Collaboration with law enforcement.

These four components provide the framework for a behavioral health crisis response system that has parity with the existing emergency response system for physical health.

Essentially: Someone to call, someone to respond, and somewhere to go.

Implementing a Crisis Now Model throughout Montana requires an enormous amount of coordination and collaboration with stakeholders. To that end BHDD has collaborated with the Montana Healthcare Foundation and the Montana Public Health Institute to host a series of monthly calls related to crisis system development. These calls were utilized for stakeholder engagement for the restructuring of the Montana's crisis system. This resulted in BHDD adopting policies to include non-Medicaid crisis services that mirror those covered under Medicaid. BHDD also amended its crisis stabilization policy to account for crisis receiving and stabilization programs. Several stakeholders are currently using County Tribal Matching Grant funds to operate mobile crisis teams, which are an integral piece of the Crisis Now model. As a result, this group also helped shape the drafted policies for that service. While BHDD has accomplished much over the past two years, we continue to move forward with several other initiatives outlined within our strategic plan. BHDD is continuing to work on restructuring crisis-related Medicaid and state general fund programs with the goal of providing sustainable funding and increasing the availability of effective crisis programming. BHDD has taken the next step and recently submitted a state plan amendment to add mobile crisis response services and mobile crisis care coordination as covered services.

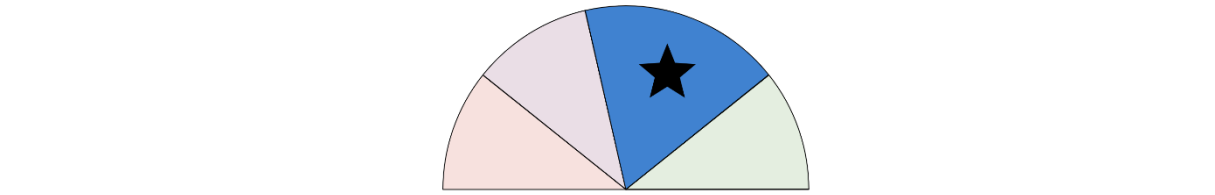

Figure 6 - Treatment section of continuum of care.

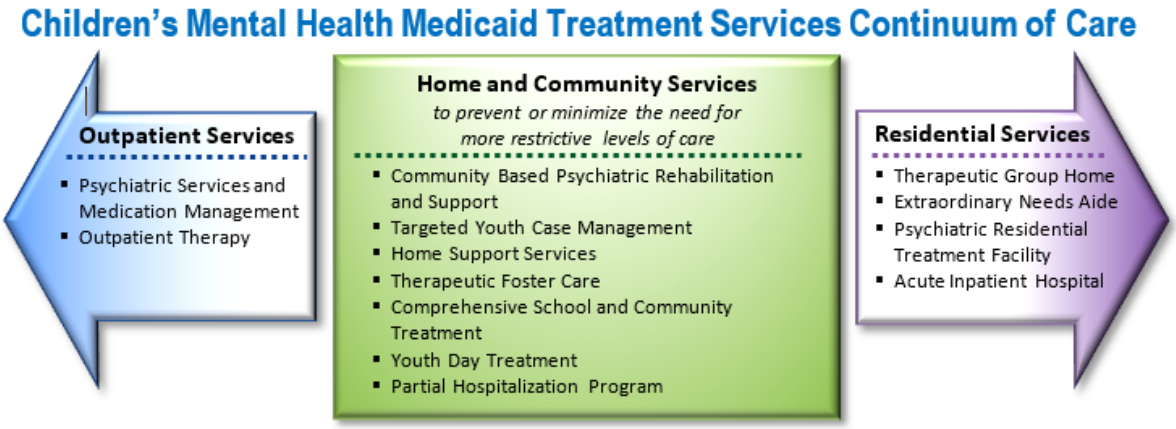

Figure 7 - Children's mental health treatment programs.

Children's Mental Health Treatment Services

The Children's Mental Health Bureau (CMHB) supports and strengthens Montana youth and families through the provision of Medicaid mental health services. Services range from home and community-based services to facility-based services. CMHB managed and funded mental health services for nearly 22,000 youth enrolled in Montana Medicaid in FY 2022.

Community Based Services

Community-based services such as Outpatient Therapy, Targeted Case Management, Comprehensive School and Community Treatment, and Home Support Services are supportive interventions added to a child's everyday life. These services focus on improving a youth's functional level by facilitating the development of appropriate behavioral and life skills. CMHB funds services that span the entire continuum of the behavioral health service spectrum. These services range from 24 sessions of preventive Outpatient Therapy to Acute Inpatient Hospitalization and Residential Treatment.

The Bureau strives to emphasize community-based services as opposed to institutional services in order to maintain children within their homes, schools, and communities. Throughout the biennium, the bureau has completed work to improve quality and access to Targeted Case Management, Home Support Services, and Comprehensive School and Community Treatment.

Enhancements to the service included family engagement, operational flexibility for providers, and outcome measurements. Of the 21,895 youth who received children's mental health services in FY 2022 99.9% received community-based services. This demonstrates not only CMHB's commitment to community-based services, but also that essentially all children who receive services in a facility also receive services within the community.

"'Vivian' is the mother of young child 'Samantha', who was placed in a therapeutic foster home due to the trauma of physical and sexual abuse. The perpetrators were unsafe adults who were allowed in the home throughout Samantha's childhood.

Through a neuropsychological evaluation and work with Vivian, it became clear that she did not know how to make safe decisions for her child. In aftercare planning for the reunification of the family, a team consisting of a targeted case manager, home support specialist, and outpatient therapist worked with the group care staff and family prior to discharge for a supported transition home and no gap in services.

This team continues to work with the family, strengthening Vivian's parenting skills and deepening the parent-child relationship."

Barb Cowan, Executive Director, Partnership for Children

Standardized Functional Assessment

CALOCUS-CASII is a standardized assessment tool used to make medical necessity determinations and provide level-of-service intensity for children and adolescents aged 6 to 18. The CALOCUS-CASII assesses service intensity needed across six dimensions.

CMHB implemented this tool in Targeted Case Management, Home Support Services, and Comprehensive School and Community Treatment. Additionally, CALOCUS-CASII has been utilized as a tool by the Child and Family Services Division to support the implementation of the Family First Prevention Services Act.

CALOCUS-CASII currently serves two major functions within CMHB. First, it has been utilized as medical necessity criteria in Home Support Services and Comprehensive School and Community Treatment. CMHB will continue to expand the use of the CALOCUS-CASII as medical necessity criteria throughout the continuum of care. The second function of the CALOCUS-CASII is for individual providers to use assessment findings to drive treatment planning and define desired treatment outcomes. CMHB is currently exploring additional ways to use the CALOCUS-CASII to reduce reliance on higher levels of care, reinforce quality of care, and collect meaningful data to inform decision making and policy design.

Comprehensive School and Community Treatment Update

CSCT is an outpatient service provided by Mental Health Centers under contract with public school districts: the school district is the provider of record. Services are focused on improving the youth's functional level by facilitating the development of skills related to exhibiting appropriate behaviors in the school and community settings.

As directed by the 2023 Legislative session through HB2 and HB872, CMHB worked collaboratively with the Office of Public Instruction on transitioning the fiscal administration of CSCT back to DPHHS. CMHB created several training resources and hosted training opportunities for school districts, mental health centers, and other stakeholders. CSCT Program rules and requirements that became effective on October 1, 2021, will remain the same and CMHB will continue to oversee the programmatic, enrollment, and claims aspects of CSCT in addition to the collection and administration of the intergovernmental transfer process.

The CSCT IGT process transferred to DPHHS effective July 1, 2023.

Children's Mental Health Medicaid Treatment Services Continuum of Care Descriptions

Psychiatric Services and Medication Management
Medication treatment and monitoring services typically include the prescription of psychoactive medications by a physician (e.g., psychiatrist) that are designed to alleviate symptoms and promote psychological growth. Treatment includes periodic assessment and monitoring of the child's reaction(s) to the drugs(s).

Outpatient Therapy
Psychotherapy and related services provided by a licensed mental health professional including individual, family, and group therapy.

Note: *Some services can be offered concurrently with other services. Other services have restrictions or exemptions.*

Please refer to the Children's Mental Health Bureau Medicaid Provider Manual for requirements.

https://dphhs.mt.gov/dsd/CMB/Manual

Community Based Psychiatric Rehabilitation and Support (CBPRS)
Adaptive skill building and integration services provided in-person for a youth in home, school or community settings in order to help the youth maintain participation in those settings. The focus of the services is to improve or restore the youth's functioning in identified areas of impairment to prevent or minimize the need for more restrictive levels of care.

Targeted Youth Case Management (TCM)
Services furnished to assist youth and families in gaining access to needed medical, social, educational, and other services. Case management services include assessment, determination of need, development and periodic revision of a specific care plan, referral and related activities, and monitoring and follow-up activities.

Home Support Services (HSS)
In-home therapeutic and family support services for youth living in biological, adoptive or kinship families who require more intensive therapeutic interventions than are available through other outpatient services. Services are focused on the reduction of symptoms and behaviors that interfere with the youth's ability to function in the family and facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care.

Therapeutic Foster Care (TFOC or TFC)
TFC services are in-home therapeutic and family support services for youth living in a therapeutic foster home environment, for youth unable to live with their biological or adoptive parents, in kinship care, or in regular foster care. These youth require more intensive therapeutic interventions than are available through other outpatient services. Services focus on skill building and integration for adaptive functioning to minimize need for more restrictive levels of care and to support permanency or return to the legal guardian.

Comprehensive School and Community Treatment (CSCT)
A comprehensive planned course of community mental health outpatient treatment that includes therapeutic interventions and supportive services provided in a public school-based environment in office & treatment space provided by the school. Services are focused on improving the youth's functional level by facilitating the development of skills related to exhibiting appropriate behaviors in the school and community settings.

Youth Day Treatment (Day Tx)
A set of mental health services provided in a specialized classroom setting (not a regular classroom or school setting) and integrated with educational services provided through full collaboration with a school district. The services are focused on building skills for adaptive school and community functioning and reducing symptoms and behaviors that interfere with a youth's ability to participate in their education at a public school, to minimize need for more restrictive levels of care and to support return to a public school setting as soon as possible.

Partial Hospitalization Program (PHP)
Structured day program provided by a hospital under the direction of a physician with frequent nursing and medical supervision. Partial hospitalization has acute level and sub-acute level services.

Therapeutic Group Home (TGH)
A community-based treatment alternative provided in a structured group home environment. TGH is appropriate for youth requiring specific therapeutic treatment services and social supports which require higher intensity of specific therapeutic services and social supports than are available through traditional outpatient services and exceed the capabilities of support systems for the youth.

Extraordinary Needs Aide (ENA)
Extraordinary needs aide services are additional one-to-one, face-to-face, intensive short-term behavior management and stabilization services provided in the TGH by TGH staff

Psychiatric Residential Treatment Facility (PRTF)
Provides interventions directed at addressing and reducing the specific impairments that led to the admission and at providing a degree of stabilization that permits safe return to the home environment and/or community-based services. A PRTF is a secure residential facility that typically serves 10 or more children and youth and provides 24-hour staff and psychiatrist supervision, and may include individual therapy, group therapy, family therapy, behavior modification, skills development, education, and recreational services.

Acute Inpatient Hospital
Psychiatric facilities that are devoted to the provision of inpatient psychiatric care for persons under the age of 21 for observation, evaluation, and/or treatment. Services are medically oriented and include 24-hour supervision; services may be used for short-term treatment and crisis stabilization. A youth might be admitted to an acute hospital if s/he is considered dangerous to self or others.

Figure 8 - Children's mental health treatment services with descriptions.

Adult Mental Health Treatment

The Treatment Bureau manages the delivery of publicly funded mental health services for adults with a mental health diagnosis, primarily focused on individuals with severe and disabling mental illness. Services range from home and community-based services to residential services.

Rehabilitative Services

Rehabilitative services such as Outpatient Therapy, Targeted Case Management, Day Treatment, and Assertive Community Treatment are services intended to help individuals develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills. Rehabilitative services are delivered in the community with the goal of maximizing the reduction of mental disability and the restoration of a member to their best possible functional level. The Treatment Bureau managed and funded rehabilitative mental health services for approximately 60,000 adults enrolled in Montana Medicaid in FY 2022.

Severe and Disabling Mental Illness (SDMI) 1915(c) Home and Community Based Services (HCBS)

The SDMI HCBS waiver provides long term supports that are comprised of supportive, independent living, habilitative, and other services. SDMI HCBS services are intended to provide an individual with a SDMI a choice of receiving long term care services in a community setting as an alternative to receiving long term care services in a nursing home setting. The Treatment Bureau currently funds services for 490 adults enrolled in the SDMI HCBS waiver.

Substance Use Treatment

Substance use is a major public health issue in the state of Montana, affecting individuals and families across the lifespan. Over the past decade, BHDD has expanded access to evidence-based treatment and recovery services. Medicaid, Medicaid Expansion, and other innovative programs being implemented in Montana are significantly expanding access to substance use disorder treatment. Montana Medicaid funds an array of community-based treatment programs to provide services to individuals in their own community which spans outpatient, residential, and inpatient services based on the nationally recognized American Society of Addiction Medicine (ASAM) Criteria. The ASAM Criteria is an evidence-based practice that is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer or discharge of individuals with addiction and co-occurring conditions.

BHDD has partnered with DPHHS' Licensure Bureau to further align Montana's substance use disorder treatment services with The ASAM Criteria. In addition, as part of the Healing and Ending Addiction through Recovery and Treatment (HEART) Initiative, BHDD submitted a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) with an October 1 ,2022 effective date. This state plan amendment added the following three levels of care to Montana's Medicaid benefit plan:

- ASAM 3.1: Clinically Managed Low Intensity Residential
- ASAM 3.2: Clinically Managed Residential Withdrawal
- ASAM 3.3: Clinically Managed Population Specific High Intensity Residential

With the addition of these three ASAM Levels of Care, Montana's Medicaid benefit plan now includes a comprehensive offering of all ASAM levels of care.

Treatment for Opioid and Stimulant Use Disorders

Although the state has made progress in addressing SUD, more work is required to expand access to SUD prevention, treatment, and recovery support services and prevent drug overdoses. Medication for Opioid Use Disorder (MOUD) utilizes a care team to provide individuals experiencing an Opioid Use Disorder with treatment to reduce or eliminate reliance on opioids. Authorized medications include methadone, buprenorphine, and naltrexone, all of which work to mitigate opioid receptors.

Figure 9 - Recovery medication for opioid use disorder.

Montana is currently operating seven TReatment for Users of STimulants (TRUST) sites and is currently developing an RFP for three Medication for Opioid Use Disorder (MOUD) sites. Both TRUST and MOUD include Contingency Management (CM) which is currently paid for with the State Opioid Response (SOR) grant. BHDD is working to establish Medicaid reimbursement for Contingency Management within the HEART 1115 Waiver. Contingency Management is an evidence-based treatment for substance use disorders and has demonstrated considerable effectiveness for treating stimulant use disorders and increasing client retention in treatment programs. Contingency Management reinforces positive behaviors by providing small, monetary incentives to individuals who successfully screen negative for stimulants throughout the duration of the program.

RECOVERY

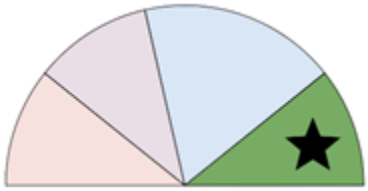

Figure 10 - Recovery section of continuum of care.

Recovery services provide the ongoing support for individuals to successfully maintain their recovery from substance use and mental illness. Peer support services are a critical resource for individuals in recovery as they are provided by individuals who have lived experience with behavioral health challenges who have successfully maintained their own recovery. Certified Behavioral Health Peer Support Specialists (CBHPSS) guide individuals through their treatment and recovery processes by providing an additional supportive service based on mutual understanding. CBHPSS trainings are available at no cost to individuals seeking to obtain their certification and services are currently funded by both Medicaid and federal grant funding.

The four major dimensions of recovery include health, home, purpose, and community. Drop-In Centers promote the four dimensions of recovery by providing community-based, recovery-support services in a low-barrier, peer-led setting. Individuals experiencing behavioral health needs, seeking resources, or maintaining their recovery are able to attend support groups and skill development classes, receive supportive services and referrals to other social service providers, establish healthy relationships, and reengage productively within their community. Montana currently has eight Drop-In Centers across the state. BHDD is also leading the process to establish a Montana affiliate of the National Alliance of Recovery Residences (NARR). The affiliate will certify recovery residences that meet the standards established by NARR so individuals in need of safe, substance-free, community-based housing can access quality services.

SUICIDE PREVENTION PROGRAM

In 2007, MCA 53-21-1101 established a suicide prevention coordinator attached to the Director's Office of DPHHS. Since then, the position has been reassigned to the BHDD Division and over the last decade has been working with stakeholders across the state to bring the issue of suicide to the forefront and ensure that suicide prevention efforts in Montana are informed by national research and current best practices.

A list of resources implemented or expanded through the suicide prevention program in the past biennium includes:

Implementation of the 988 Crisis Line

The national suicide prevention Lifeline was changed from 1-800-273-8255 to 988 on July 16, 2022. 988 is more than just an easy-to-remember number, it's a direct connection to compassionate, accessible care and support for anyone experiencing mental health-related distress. People can also dial 988 if they are worried about a loved one who may need crisis support.

Montana currently has three regional crisis call centers that receive approximately 10,000 calls a year. Over the past six months, there has been a 30% increase in calls with 98% of all calls being handled in-state. Over the past year, the answer time rate has dropped from 32 seconds to 13 seconds with approximately 72% of calls having the issue resolved on the phone.

Montana Zero Suicide Grant

Based on research that shows most people who attempt suicide had seen a health care professional within a month of their attempt, Zero Suicide is a systematic approach to identifying and addressing suicidality within the larger healthcare system. The goals of Montana's Zero Suicide grant include:

- Establishing a suicide care policy promoting suicide safe care as an organizational priority.
- Creating a confident and competent workforce where at-risk individuals are identified.
- Ensuring all patients who are at risk receive immediate, safe and personalized treatment

Accomplishments to date:

- All-site calls have led to a good exchange of information between Tribal Health Facilities and Urban Indian Health Centers.
- Trainings have been done with all partners
- Tribal Consultation has led to increased collaboration between the state and Tribal Partners, which has led to more partners
- NativeWellness Life, a Native owned magazine, has been a strong conduit of education, outreach and support
- Facilities have been creative: having Zoom classes in ribbon skirt making and beading, supporting individual patients with the ability to have fresh food grown at home, and the development of community gardens.
- Partners have developed clear policies and procedures and trained all staff to support their patients that may be at risk of suicide.

Rural Community Suicide Postvention Toolkit

In collaboration with Columbia University, a postvention toolkit is meant to be used after a suicide occurs in a local community. It provides a series of action steps that a community can take to safely offer support and reduce the risk of additional suicides from occurring in their community. These efforts are collectively referred to as **suicide postvention** because the response occurs after a suicide has happened.

Suicide Prevention Toolkit for Primary Care Physicians

Suicide assessment and intervention training designed for healthcare providers practicing in rural communities.

- Training provided every semester for college students in nursing, P.A., social work, counseling, and psychology.
- Project ECHO for pediatricians
- Training at numerous medical conferences
- Training for the Montana Medical Association
- Collaboration with the National Council for Mental Wellbeing to provide train-the-trainer in Suicide Safe Care so that Montana has over 80 trainers around the state.

Suicide Prevention Trainings

Over the biennium, more than 2,900 community members, employers, first responders, educators, and others were trained in suicide awareness. In addition,**1,900** healthcare and behavioral health providers were trained in suicide risk assessment and intervention.

Community Suicide Prevention Grants

Through HB118 passed in 2017, $500,000 in community grants are awarded annually to entities around the state that provide research-based interventions to identify risk, increase resiliency skills, and increase suicide awareness in high-risk populations. The high-risk populations include American Indians, veterans, youth, LGBTQ+, individuals with SUD, individuals with chronic pain, and middle-aged men.

DEVELOPMENTAL DISABILITIES PROGRAM

The mission of the Developmental Disabilities Program (DDP) is to create a system that coordinates resources and supports and provides services for individuals to have meaningful lives in their communities. DDP offers community based developmental disability services for individuals throughout their lifetime.

DDP managed and funded services for 3,320 Montanans with developmental disabilities in FY 2022. Services are primarily delivered through Medicaid waiver and State Plan services. Of the 3,386 individuals served by DDP in FY 2022, 99.7% received a community-based service. DDP serves the entire continuum of developmental disability needs from individuals who require minimal support to thrive in the community to individuals with very intensive needs who require 24-hour care.

Home and Community Based Services Waiver

The DDP's Home and Community Based Service (HCBS) Waiver is the 0208 Comprehensive Waiver (HCBS DD). This waiver is designed to support successful community living for individuals with developmental disabilities and offers an important alternative to institutionalization. The 0208 Waiver includes 32 separate services such as supported living and other residential services, behavioral support, employment support, day program services and transportation.

The DDP serves around 2,500 Montanans with a developmental disability through the HCBS DD waiver. These services are in addition to the standard Medicaid benefit package. The services an individual receives and the cost of those services range significantly depending on the needs of the individual. The DD waiver is designed to meet a wide variety of needs for the duration of the individual's life.

Developmental Disabilities Program

Member Success Story

"I like the quiet, and my favorite part of my day is drinking coffee with staff," is what Logan says about living a life with greater independence.

With a lot of hard work on developing independence skills and advocation for himself, Logan moved out of the group home and into his own apartment with reduced direct supports. This adjustment required Logan to start using his cell phone to reach out, and a lot of reaching out he did, initially!

Logan learned WHEN he should reach out and how often. With more hard work he learned how and when to text his questions and needs. Logan has since texted the manager Megan, not with a question or a concern but rather just a text wishing her a good day.

Medicaid State Plan Services

Targeted Case Management (TCM) is available to individuals of any age that are enrolled in DDP Waiver services, as well as individuals ages 16 and older who have been determined eligible for the Developmental Disabilities Program. TCM services are comprehensive and include assessment of an eligible individual, development of a specific care plan, referral to services, and monitoring of those services. These services are delivered across the state by either a DDP-employed Case Manager or a Contracted Case Manager. Approximately 3,100 individuals statewide are currently enrolled in TCM for individuals with Developmental Disabilities.

Applied Behavioral Analysis (ABA) is a type of therapy that can improve social, communication, and learning skills through positive reinforcement. This therapy is provided by a licensed Board-Certified Behavior Analyst (BCBA). BHDD utilized significant stakeholder input to make changes to these services with a goal of reducing barriers by putting more choice and control in the hands of families and providers. As a result of these changes, BHDD anticipates an increase in utilization and number of members served in the next biennium. Montana Medicaid members may now be eligible for ABA services with the following diagnoses:

- Autism Spectrum Disorder (ASD) (the member is no older than 20 years of age).
- Serious Emotional Disturbance (SED) (the member is no older than 17 years of age or the member is no older than 20 years of age and enrolled in an accredited secondary school and meet certain functional impairment criteria).
- Intellectual and/or Developmental Disability (defined as having been deemed eligible for the receipt of state sponsored developmental disabilities services and no older than 20 years of age) and meet certain functional impairment criteria.

RECENT HIGHLIGHTS AND ACCOMPLISHMENTS

BEHAVIORAL HEALTH FOR FUTURE GENERATIONS (BHSFG)

The Montana Department of Public Health and Human Services (DPHHS), in partnership with the Governor's Office and a newly designated Legislative Advisory Commission created during the 68th Montana State Legislative Session, has embarked on The Behavioral Health System for Future Generations (BHSFG) Initiative. The Initiative, approved in House Bill 872 during the 68th legislative session, set aside $225 million in a new state account that will be used to fund state and community-based programs for people with behavioral health needs or developmental disabilities over a multi-year period. Another $75 million would go into the state's long-range building fund for future capital projects in the behavioral health system. The money in the new state fund will be used for studying and planning comprehensive behavioral health developmental disabilities systems and investing in community-based providers to stabilize service delivery, support the workforce, and increase service capacity.

BEHAVIORAL HEALTH (BH) AND INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD) ALTERNATIVE SETTINGS

The Alternative Settings workstream of the Behavioral Health for Future Generations initiative aims to improve access to evidence-based behavioral health, developmental disabilities, and substance use disorder care programs and services by expanding the community-based care models to support the individuals in the least restrictive level of care.

A crucial part of our efforts focuses on engaging stakeholders. Recognizing the vital role that stakeholders play in designing and implementing alternative settings initiatives, the Department has invited a diverse (both in perspective and geography) group of individuals to participate in an Alternative Settings subcommittee and Steering Committee. These committees include healthcare providers, community leaders, individuals with personal experiences, and representatives from advocacy organizations. The Subcommittee and Steering committee members actively participate in public meetings, providing valuable feedback during the planning and implementation stages of the Alternative Settings work.

Through this collaboration with a diverse set of stakeholders, the Department intends to incorporate input from various perspectives across the care continuum, ultimately shaping an improved behavioral health system that benefits both current and future Montanans.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS (CCBHC)

A CCBHC is a federally designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs serve anyone who walks through the door, regardless of their diagnosis and insurance status. As an integrated and sustainably financed model for care delivery, CCBHCs ensure access to integrated, evidence-based substance use disorder and mental health services, including 24/7 crisis response and medication-assisted treatment (MAT).

CCBHCs must meet stringent criteria regarding timeline of access, quality reporting, staffing and coordination with social services, criminal justice, and education systems. Providers of these services under the model, receive flexible funding to support the real costs of expanding services to fully meet the need for care in their communities. Goals include increasing access to mental health and substance use disorder treatment, expanding states' capacity to address the overdose crisis, and establishing innovative partnerships with law enforcement, schools, and hospitals to improve care, reduce recidivism, and prevent hospital readmissions.

HEALING AND ENDING ADDICTION THROUGH RECOVERY AND TREATMENT (HEART)

Governor Gianforte's HEART Initiative, included in HB 701, seeks to invest significant state and federal funding to expand the state's behavioral health continuum to:

- Expand efforts to strengthen state's evidence-based behavioral health continuum of care for individuals with a SUD, Serious Mental Illness (SMI), or a Serious Emotional Disturbance (SED);
- Enable prevention and earlier identification of behavioral health issues; and
- Monitor the quality of care delivered to members with behavioral health needs across all settings through improved data collection and reporting.

The HEART initiative refers to the package of programs and services that will be provided using HEART funding, Medicaid state plan, and the substance abuse block grant. The HEART waiver is specifically one piece of the HEART initiative and refers to the 1115 behavioral health waiver for which BHDD has applied.

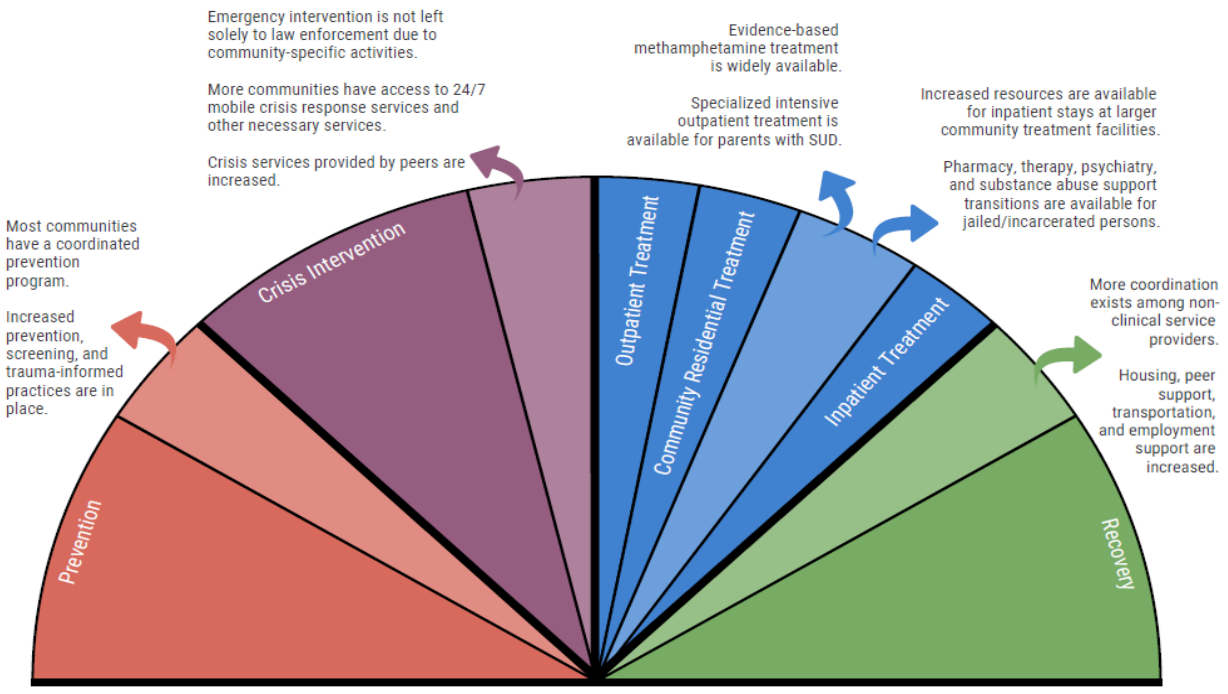

Figure 11 - Continuum of care with resource information.

Through the HEART Initiative, BHDD has expanded services and supports across the state using a variety of methods.

Grants to Tribes

The HEART funding provided $500,000 in grants to be issued directly to Tribal Nations each year for substance use disorder (SUD) prevention; mental health promotion; mental health crisis, treatment, and recovery services; and tobacco prevention and cessation. Tribal Nations are in their second year of grants. DPHHS will receive an annual report from each Tribal Nation with specific details of how the funds were utilized according to the goals.

Grants to Detention Facilities

Local county and tribal detention facilities had the opportunity to apply for grants to support the implementation of a comprehensive behavioral health continuum within their facilities. The Department funded seven counties with two-year grants to implement jail-based behavioral health therapy, Certified Behavioral Health Peer Support Services, care coordination, medication management, and Medication for Opioid Use Disorder Treatment. Funding available each year included $1,100,000 in HEART funding and $500,000 in substance use block grant funding.

Medicaid State Plan Services

BHDD now has an approved state plan amendment effective October 1, 2022, which included the following three levels of care of the American Society of Addiction Medicine (ASAM):

- ASAM 3.1: Clinically Managed Low Intensity Residential Services
- ASAM 3.2: Clinically Managed Residential Withdrawal Management
- ASAM 3.3: Clinically Managed Population-Specific High Intensity Residential Services

That approved state plan amendment also BHDD also added crisis stabilization as two tiers: crisis receiving and crisis stabilization. Crisis receiving services are intended for individuals who can be stabilized in less than 24 hours. Crisis Stabilization services are for those individuals who require observation and stabilization lasting beyond 24 hours.

Community mobile crisis intervention services are a critical part of states' crisis and behavioral health systems of care. BHDD collaborated with the Western Commission for Higher Education to complete a statewide assessment to provide recommendation regarding:

- Development of additional mobile crisis teams including outlining what types of mobile crisis services will work, particularly in rural and frontier areas;
- Considerations regarding how licensing and reimbursement structures can facilitate statewide mobile crisis coverage; and
- Necessary changes to policy landscapes.

BHDD submitted a state plan amendment effective July 1, 2023, to add mobile crisis response services and mobile crisis care coordination as Medicaid covered services.

HEART 1115 Demonstration Waiver

On October 1, 2021, DPHHS submitted a Section 1115 Demonstration Waiver (HEART Waiver) to the Centers for Medicare and Medicaid to build upon the strides made by the state over the last

decade to establish a comprehensive continuum of behavioral health services for Medicaid members. The HEART Waiver is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through the HEART Initiative.

The HEART Waiver application was bifurcated, and the first piece of the Demonstration was approved July 1, 2022. The first approval granted expenditure authority to allow Medicaid reimbursement for short-term SUD treatment at Institutions of Mental Disease (IMD). There are currently four facilities providing treatment (ASAM 3.5 - Clinically Managed High Intensity Residential Services) under this authority:

- Rimrock, Billings, MT - licensed for 40 residential beds.
- Badlands Treatment Center, Glendive, MT - licensed for 32 residential beds.
- Cramer Creek, Clinton, MT – licensed for 77 beds.
- Montana Chemical Dependency Center – licensed for 40 beds.

Through the HEART Waiver, DPHHS is also seeking to add new Medicaid Services which include:

Contingency Management: Contingency Management is a best practice, outpatient treatment model for Medicaid members ages 18 and older with stimulant use disorder (e.g., cocaine, methamphetamine, and similar drugs). Contingency Management is a behavioral-modification method that provides immediate reinforcement for individuals adhering to the goals of the program. The contingency management program provides small rewards to individuals who screen negative for stimulants.

Tenancy support: Tenancy support services is a program to assist Medicaid members ages 18 and older with SUD, SMI, or SED, who are experiencing chronic homelessness or frequent housing instability and frequently engage with crisis systems and institutional care. Tenancy support services will include pre-tenancy supports and tenancy sustaining services to support an individual's ability to prepare for and transition to housing, as well as assisting individuals in maintaining services once housing is secured.

Targeted Medicaid re-entry services: Targeted Medicaid re-entry services are provided to justice-involved individuals from Montana state prisons in the 30 days prior to release. Re-entry services include limited community-based clinical consultation services provided in-person or via telehealth, in-reach care management services, Medication Assisted Treatment (MAT) for all types of SUDs, and a 30-day supply of medication for reentry into the community. Individuals will also receive coverage of medications that include long acting or depot preparations for chronic conditions (e.g., schizophrenia, SUD); acute withdrawal medications; or suppressive, preventive or curative medications, include PrEP and PEP (HIV, HCV, and SUD) that will facilitate maintenance of medical and psychiatric stability upon release.

CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT EVALUATION

During a significant overhaul of Targeted Case Management (TCM) in 2020, the Children's Mental Health Bureau (CMHB) designed its TCM model to emphasize assisting and empowering families of children with SED to obtain the necessary services to remain in school, at home, and out of trouble. Together, the CMHB and the University of Montana's Center for Children, Families, and

Workforce Development (the Center) developed the following evaluation objectives: manage fidelity to program model, with an emphasis on family engagement, demonstrate effectiveness of TCM, and provide actionable recommendations for improvements to the program or further evaluation.

Through the evaluation, the Center offered 19 actionable recommendations for the improvement and further evaluation of the CMHB TCM System in five broad categories: Claims Data, MHSIP Data, HB 583/589, Fidelity to Program Standards, and CASII/ECSII.

CMHB has evaluated and prioritized implementation of these recommendations beginning with the development of a Fidelity to Family Engagement Tool which will be used to perform quality reviews to promote and measure quality family engagement and utilization of the "golden thread." The golden thread is the consistent inclusion of relevant clinical and environmental information throughout all stages of mental health treatment. Beginning at intake and assessment through the utilization of the CALOCUS/CASII functional assessment, clinical assessment, and needs assessment, the family and youth's strengths, preferences, and needs should be clearly identified in treatment plans.

Fidelity Marker	Rule/ Authority	Not yet	Emerging	Developing	Proficient	Advanced
Treatment Planning	37.87.823 (5) Case management plans for youth with SED must be completed within the first 21 days of admission to targeted case management services and updated at least every 90 days or whenever there is a significant change to the youth's condition. The case management plan must: (a) use the standardized assessment tool approved by the department to determine the appropriate level of service intensity needed by the youth and the youth's family or care-givers; (b) incorporate standardized assessment tool findings into the plan; (e) identify the strengths of the youth and the youth's family or caregivers	Treatment plans do not exist or are clearly electronically cloned and lack any level of individualization.	Treatment plan is in place but not highly individualized. Generic treatment goals utilized across client groups. No indication that treatment plan is driven by treatment team including youth served, family or caregivers.	Treatment plan sections are completed and minimally include crises (urgent and emergent needs and planning), strengths, natural supports, support of family and caregivers, and at least 1 goal clearly linked to functional assessment.	Plan identifies specific skills to be developed. Plan is based on assessed strengths. Plan utilizes CASII scores and dimensions to determine appropriate areas of priority and determine the appropriate level of service intensity needed by the youth and the youth's family or caregivers.	There is a clear link between assessment information and all treatment plan goals. All treatment goals are definable, measurable and data is collected to demonstrate attainment The plan is regularly updated (every 90 days) in a way that reflects use of data, ongoing assessment and developing strengths and skills The family and caregiver skills needed to case manage themselves are identified and targeted as goals.

Figure 12 – Sample from Fidelity to Family Engagement Audit Tool. Credit: University of Montana

OUT OF STATE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY QUALITY ASSURANCE AND CLINICAL OVERSIGHT

In the fall of 2022, CMHB implemented a process for quality audit reviews (QAR) to ensure quality care of youth receiving treatment in out of state Psychiatric Residential Treatment Facilities (PRTF). QAR relates to all aspects of care provision and management in-line with best practices, applicable Administrative Rules of Montana, Code of Federal Regulations, and the CMHB Provider Manual.

The purpose of the QAR is to monitor compliance of rules and regulations, support provider education, review of quality treatment by licensed clinicians, and review of psychiatric medication prescribing practices. Each quarter a random sampling of youth receiving treatment in out of state PRTFs are selected. The clinical team requests and reviews clinical files for selected youth with an

established and consistent evaluation tool and makes recommendations that may include provider education or corrective action plans.

The Children's Mental Health Bureau provides care coordination and oversight to youth who are placed in out of state PRTFs when in state providers are not able to meet their mental health needs.

In addition to QARs, each Montana youth is assigned a care coordinator at admission to a PRTF. The care coordinators are licensed mental health professionals and a valuable resource to treatment planning teams. Care coordination activities include navigating Montana medical necessity criteria, educating treatment teams on resources and treatment options available for youth, and collaborating on discharge planning. The care coordinators also engage in any follow up recommended through the QAR.

"Montana families of children with disabilities and healthcare challenges need information about available services, presented in family-friendly language with the opportunity to ask questions. The Developmental Disabilities Program has made unprecedented effort this past year to ensure families and their case managers are knowledgeable about DDP services.

DDP leadership has been responsive and available to help navigate particularly complex family situations, and the implementation of regular PoP (Partnering our Programs) meetings has meant more direct family engagement than ever before. The clear result is better service for Montana's most vulnerable children, and more informed case managers serving them."

Shawna Hanson, F2F Outreach Coordinator

DEVELOPMENTAL DISABILITIES PROGRAM FAMILY ENGAGEMENT INITIATIVES

National Core Indicators

DDP began using National Core Indicators (NCI) in July 2021. NCI is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The purpose of the program, which began in 1997, is to support State Developmental Disabilities agencies to gather a standard set of performance and outcome measures that can be used to track their own performance over time, to compare results across states, and to establish national benchmarks.

In Montana's first year of membership, DDP utilized the Adult Family Survey, Child Family Survey, and Staff Stability survey. In the second year of membership, DDP deployed Quality Improvement Specialists to meet directly with individuals in services to gather feedback through the in-person NCI survey. These survey results will be analyzed to provide important information to DDP which will used to look at outcomes, set priorities, and develop policies.

Family to Family

Beginning in 2021, DDP began partnering with Family to Family (F2F), which is Montana's Family Health Information Center. F2F is housed in the Rural Institute for Inclusive Communities on the University of Montana Campus. This collaboration provides an important opportunity for DDP to provide information directly to individuals in services and their family members as well as obtain

feedback from this important part of the service delivery system. To date, DDP and F2F have conducted six evening presentation/listening sessions with more planned.

ESTABLISHMENT OF THE BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES DIVISION

The merger of the AMDD and DSD into the BHDD has created many efficiencies in operations, communications, and provider relations. In addition to administering services across the entire behavioral health continuum, it has provided the opportunity for the Prevention and Treatment Bureaus and the Children's Mental Health Bureau to work more cohesively on programs which impact children, such as PAX Good Behavior Game. The Children's Mental Health Bureau has also worked closely with the Prevention and Treatment Bureaus to fund programs aligning with the goals and priorities of the Children's Mental Health Bureau such as enhancing family engagement, outcome measurement, and data driven decision making. During the biennium the Children's Mental Health Bureau funded several important projects with the SAMHSA block grants including Targeted Case Management Evaluation, innovation grants and learnings collaboratives on family engagement, and a children's behavioral health focused community health worker pilot program.

REGULATORY REFORM INITIATIVES

BHDD has participated in the Department's implementation of the Regulatory Reform Initiative (RRI). During Phase 1, BHDD inventoried and reviewed over 300 administrative rules to identify areas to reduce regulatory burdens and inefficiencies for our providers so that they can focus more time delivering services to Montanans. BHDD is currently contributing to Phase 3 of the Department's RRI which consists of implementation of high-priority rule reform.

Complementary to the RRI, DDP has worked with a group of stakeholders since 2019 to reduce administrative burden within the DDP system. Areas the group has currently prioritized to streamline are the Incident Management Policy and the Personal Support Plan Policy. This work group meets monthly to continuously identify and reduce unnecessary regulations.

CROSS SYSTEM COLLABORATION

Successful cross system collaboration is an important tool in efficiently and effectively serving members who are eligible for multiple programs across the Department. This type of collaboration not only results in better outcomes for our members, but also results in opportunities for cost savings by leveraging the most cost-efficient service or funding stream. BHDD staff have steadily increased opportunities to collaborate with partner agencies over the biennium. Some examples include improved coordination of HCBS Waiver Applications between CFSD and BHDD, clinical staffing of youth involved with CFSD who are at risk of out of home treatment, and the development of a Memorandum of Understanding between Vocational Rehabilitation and DDP.