Behavioral Health Alternative Settings

Final Report

Delivered to: Montana Department of Public Health and Human Services (DPHHS)

Prepared for: House Bill 872 Behavioral Health System for Future Generations (BHSFG) Commission

Delivered by: Guidehouse

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Acronym List

ACO	Accountable Care Organization
ACT	Aligned Care Team
AI/AN	American Indian and Alaska Native
APRN	Advanced Practice Registered Nurse
ASO	Administrative Services Organization
BH	Behavioral Health (includes mental health, substance use disorders, and intellectual/developmental disabilities)
BHSFG	Behavioral Health System for Future Generations
CCBHC	Certified Community Behavioral Health Center
CMS	Centers for Medicare and Medicaid Services
DPHHS	Department of Public Health and Human Services
ED	Emergency Department
ESRI	Environmental Systems Research Institute
FDA	Food and Drug Administration
FFS	Fee For Service
FTEs	Full-Time Employee
HB	House Bill
HHS	Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
I/DD	Intellectual/Development Disabilities
IBC	Intensive Behavior Center
IBH	Integrated Behavioral Health
IHP	Integrated Health Partnerships
IHS	Indian Health Service
IOP	Intensive Outpatient Programs
IP	Inpatient
KPU	Key Planning Unit
LAC	Licensed Addiction Counselor
MDE	Major Depressive Episodes

MH	Mental Health
MICRS	Management Information and Cost Recovery System
MMIS	Medicaid Management Information System
MSH	Montana State Hospital
NAMI	National Alliance on Mental Illness
NP	Nurse Practitioner
OP	Outpatient
PACT	Patient Aligned Care Team
PCCM	Primary Care Case Manager
PCPs	Primary Care Providers
PHP	Partial Hospitalization Program
PPS	Prospective Payment System
PRTFs	Psychiatric Residential Treatment Facilities
RAEs	Regional Accountable Entities
ROM	Rough Order of Magnitude
SAMHSA	Substance Abuse and Mental Health Services Administration
SDoH	Social Determinants of Health
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TCM	Targeted Case Management
USDA	United States Department of Agriculture

Executive Summary

Governor Greg Gianforte signed House Bill (HB) 872 into law on May 22, 2023. The law established the Behavioral Health System for Future Generations (BHSFG) Commission to make recommendations to the Governor. As part of the BHSFG Commission established by HB 872, the Montana Department of Public Health and Human Services (DPHHS) retained Guidehouse ("study team" or "team") to conduct a design study of alternative behavioral and intellectual/developmental disabilities (I/DD) healthcare settings beyond existing state-run facilities. This design study was completed to inform a new care delivery system to best meet the needs of Montanans seeking acute, sub-acute, outpatient (OP), and emergent care. Design study efforts considered the needs of individuals diagnosed with behavioral health (BH) conditions, substance use disorders (SUDs), I/DD, and co-occurring health issues for both pediatrics[1] and adults.

This report is the culmination of the assessment phase, inclusive of data analysis, stakeholder engagement, and best practice research. The objectives of the report are:

- Outlining best practice approaches for enhancing BH programs and settings
- Reducing over-dependency on institutional and state-run facility settings
- Identifying suitable sub-acute, outpatient, and community-based treatment settings
- Outlining ways the State can implement the recommendations based on findings

This report provides comprehensive study findings and a series of recommendations aimed to offer Montana significant BH system improvement and to help maximize its care delivery system's ability to address the needs of all Montanans. Recommendations are described at a broad level for statewide impact. Recommendations generated via the study will be considered by the BHSFG Commission alongside broader recommendations being generated via Commission processes, meetings, stakeholder engagement, and public comments. **The recommendations are subject to the review and approval of the Commission and Governor Gianforte and are not guaranteed funding or implementation.**

The study team anticipates that several recommendations in this report, if approved by the Commission and Governor Gianforte, can be advanced using services and funding from existing and new providers in the market along with Federal, State, and private financial partnerships, which the State can request via Montana's procurement process. Following Montana's procurement process allows the State to invite input from potential partners who may have interest in collaborating to implement recommendations. A procurement process can be used to receive responses about how partners can implement improvements tailored to the specific needs and assets of local communities, to build upon the evidence gathered in this study.

Based on study observations and stakeholder input, DPHHS initiated a separate alternative settings study specific to the system of care that serves individuals with I/DD. A separate report presents the findings from the I/DD-focused study and resulting recommendations for consideration by the BHSFG Commission and the Governor.

[1] Pediatrics and pediatric populations are individuals younger than 18 years old.

Montana BHSFG Alternative Settings Recommendations

The design study initially operated with a hypothesis that the number of beds available in Montana is insufficient to support those seeking BH care. However, analyses revealed ample supply of inpatient (IP) beds, which are concentrated in one area, but not available across the State. Analyses also revealed an insufficient supply of sub-acute and OP services, creating an over-reliance on IP care. Based on these analyses, the study team expanded the focus of the study to include interventions to prevent unnecessary IP bed use.

Design study recommendations center around three focus areas that the State can implement to improve the statewide BH delivery system:

- Continuum of Care
- Access
- Workforce

There are 11 primary recommendations across the three focus areas, aimed at enhancing care delivery in the State. These recommendations were developed through extensive discussion and guidance provided by the Steering Committee, focused insights shared by Subcommittees and stakeholders, and analysis of Montana and Federal data to establish evidence-informed recommendations. The recommendations are outlined below. For further details on any one of the following recommendations, please see pages listed:

Continuum of Care

- **Recommendation 1.1.** Develop a statewide comprehensive care management role or entity to facilitate care coordination between participants in Montana's BH system.
- **Recommendation 1.2.** Enhance existing infrastructure and resources – for example CCBHC, mobile crisis, PACT/ACT, school-based programs with sustained funding.
- **Recommendation 1.3.** Incorporate culturally relevant care protocols (Tribal and others) and hire culturally relevant staff.
- **Recommendation 1.4.** Expand the use of integrated behavioral care models to support collaboration through partnerships with primary care and BH providers, enhanced reimbursement, and training.
- **Recommendation 1.5.** Spread awareness of Medicaid reimbursement for mobile crisis services (recent State Plan Amendment) to encourage its expanded utilization.

Access

- **Recommendation 2.1.** Expand community-based crisis receiving and stabilization centers.
- **Recommendation 2.2.** Enhance access to Comprehensive Behavioral Healthcare Campuses, especially in the east, to improve transitions between acute, sub-acute, and OP care.
- **Recommendation 2.3.** Increase capacity of in-state residential treatment and group homes for the pediatric population to reduce out-of-state care.

Workforce

- **Recommendation 3.1.** Create a dedicated recruitment and retention unit within state government to support expansion and maintenance of homegrown BH workforce.
- **Recommendation 3.2.** Evaluate the sustainability of expanding the scope and/or use of ancillary providers (e.g., peer support specialists, community health workers, family caregivers) to deliver BH-related services and integrate these providers into BH care teams.
- **Recommendation 3.3.** Enhance BH provider workforce capacity by ensuring Advanced Practice Registered Nurses (APRNs) have sufficient opportunity for training and clinical practice in BH, including delivery of BH services via telehealth.

Together, these recommendations support a future system that addresses BH needs in the appropriate care setting and minimizes placements at Montana State Hospital (MSH), as illustrated in Figure 1.

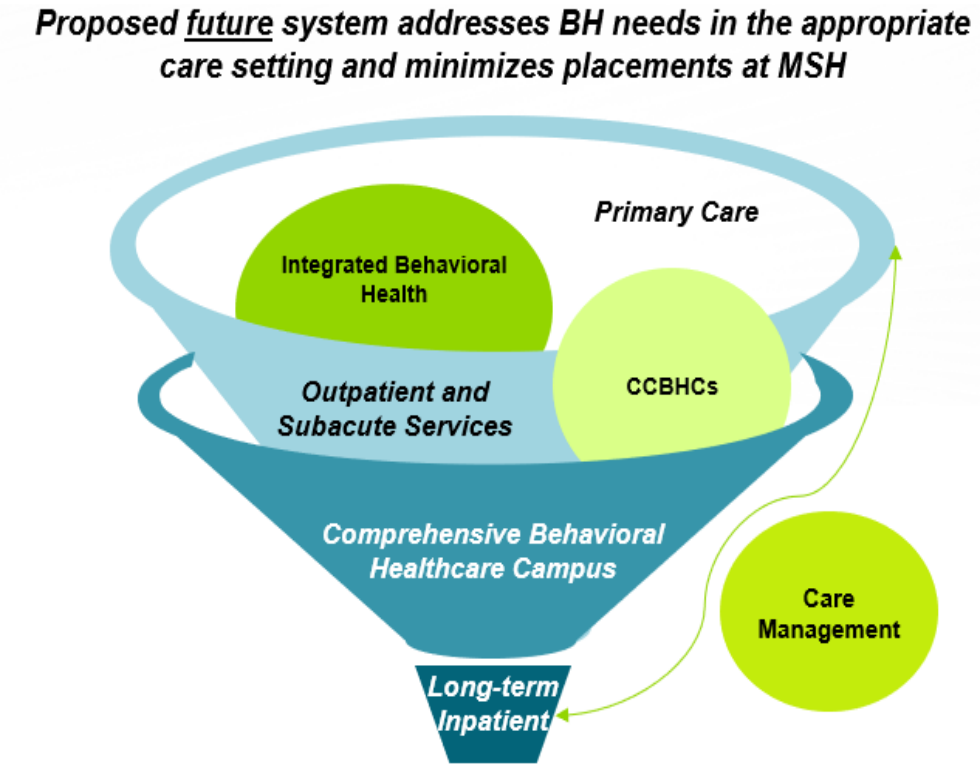


Figure 1. Proposed Future BH System

Each recommendation offers an action that, if adopted for implementation, could improve behavioral healthcare delivery throughout Montana. The study team anticipates that approval and adoption of any or all these recommendations would be a significant step in shaping the future BH landscape in Montana to better meet the needs of the comprehensive population of individuals who need and benefit from high-quality, accessible behavioral healthcare.

Background

The Need for Alternative Settings in Montana

Montana's state-run BH facilities face a crisis. Aging infrastructure, high maintenance costs, and isolation from population centers hinder individual care and workforce recruitment. MSH has been cited by the federal government for safety concerns, further highlighting the need for modernization. Access to acute behavioral healthcare is limited in large parts of the State, leading to extended stays in resource-limited facilities and hindering the achievement of the Quadruple Aim[2] – improved physical and behavioral health, reduced avoidable costs, enhanced individual experience, and improved provider satisfaction.

Figure 2 describes the theory of change for the planning of Alternative BH Settings for Montana that was approved by DPHHS leadership at the outset of the study.

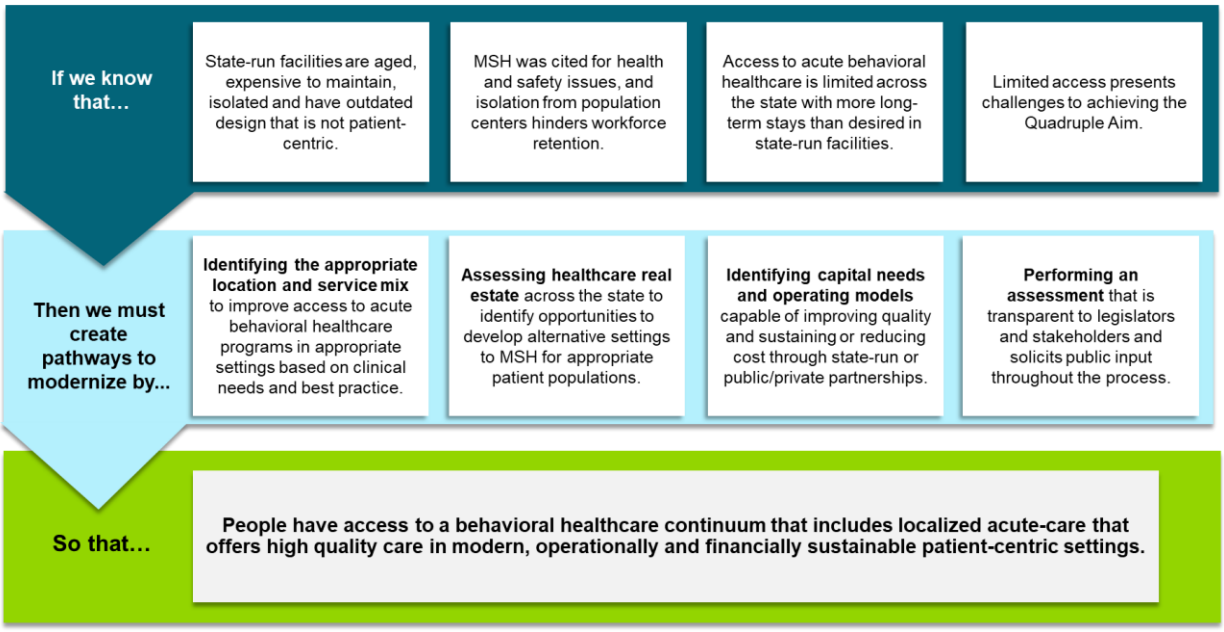


Figure 2. Theory of Change for the Creation of Alternative Settings for Montana

Challenges with the current Montana BH delivery system present the need and opportunity to explore reform and to examine where investments can make the most notable and sustainable impacts. This requires the following activities:

- **Identifying the right locations and service mix:** Promoting access to appropriate care programs across the State, tailored to individual needs and best practices.
- **Determining needed workforce:** Promoting adequate workforce to serve alternative settings and needed community BH wrap-around services.
- **Reassessing healthcare real estate:** Identifying opportunities to develop new settings that are modern, person-centric, and geographically dispersed.

[2] Bengt B. Arnetz et al., "Enhancing Healthcare Efficiency to Achieve the Quadruple Aim: An Exploratory Study," *BMC Research Notes* 13, no. 1 (July 31, 2020), https://doi.org/10.1186/s13104-020-05199-8.

- **Improving efficiency and effectiveness:** Analyzing capital needs and exploring operating models, including both state-run and public-private partnerships, to improve quality and sustain (or potentially reduce) costs.
- **Fostering transparency and collaboration:** Garnering public input and legislative transparency to learn from those experiencing, delivering, and receiving BH.

Guiding Principles

During the August 2023 Alternative Settings Steering Committee and Subcommittee meetings, the study team unveiled the guiding principles for this study. The Steering Committee and Subcommittees agreed to these principles to help actively guide collaboration and decision-making. Leveraging the inputs of various stakeholders, DPHHS adopted the following guiding principles to frame inputs and recommendations:

- **Accessibility:** The State aims to improve access to care in the least restrictive setting, at diverse locations, considering population density, workforce availability, and cost.
- **Patient-Centered Care:** The State aims to design care settings that cater to individual needs, both for individuals seeking voluntary care and for individuals requiring involuntary or civil commitment who have specialized needs.
- **Modernized System:** The State aims to develop a plan for a modern acute and sub-acute care system that addresses the Quadruple Aim (see Figure 3).

Figure 3. Quadruple Aim of a Modernized Acute and Sub-Acute Behavioral Healthcare System

- **Sustainable Model:** The State seeks to establish an operationally viable care model considering clinician location, access, workforce availability, and resource management. A sustainable care model requires cross-sector collaborations with law enforcement, housing networks, and other community partners.
- **Stakeholder Inclusion:** The State aims to promote transparency and involvement of individuals with lived experience, families, legislators, and potential partners.
- **Prompt Action:** The State will work to address challenges and plan for the future.
- **Data-Driven Decisions:** All recommendations will be informed by factual, data-driven evidence to the extent that data is available.

Approach

Design Study Elements

The study team conducted an analysis of existing BH facilities throughout the State to assess current and desired future state of alternative settings. The team performed the activities in Figure 4 from April 2023 through March 2024.

Alternative Settings Design Study Elements	Month											
	Apr.'23	May '23	Jun. '23	Jul. '23	Aug. '23	Sept. '23	Oct. '23	Nov. '23	Dec. '23	Jan. '24	Feb. '24	Mar. '24
Feasibility Assessment to Identify Setting(s) Framework	■	■	■	■	■	■	■	■	■			
Strategic Communications and Legislative Engagement	■	■	■	■	■	■	■	■	■	■	■	■
Build vs. Buy Analysis							■	■	■	■	■	
Stakeholder Engagement				■	■	■	■	■	■	■	■	■

Figure 4. Design Study Project Plan

Methodology of the Design Study

The study team engaged in three key activities: stakeholder engagement, data analysis, and qualitative best practice research throughout the design study. The study team sought DPHHS review, input, and insights through weekly meetings held with DPHHS executive staff.

Figure 5 outlines the key components of the three key study activities and the breadth of individuals engaged to understand the current state and formulate a desired future state as outlined in this report.

Figure 5. Summary of Key Study Activities

Stakeholder Engagement Governance Structure

The study team, in partnership with DPHHS, established a Steering Committee and three Subcommittees to provide input and advise on aspects of the design study. The Steering Committee included legislators, executive leadership, and subject matter experts who served in an oversight capacity, providing input, and ongoing communication to the HB 872 Commission. DPHHS also appointed members of Subcommittees to the Steering Committee to promote continuity of input across committees. All Steering and Subcommittee members provided subject matter expertise and input.

Figure 6 depicts the relationships and interactions between the Steering Committee and the three Subcommittees.

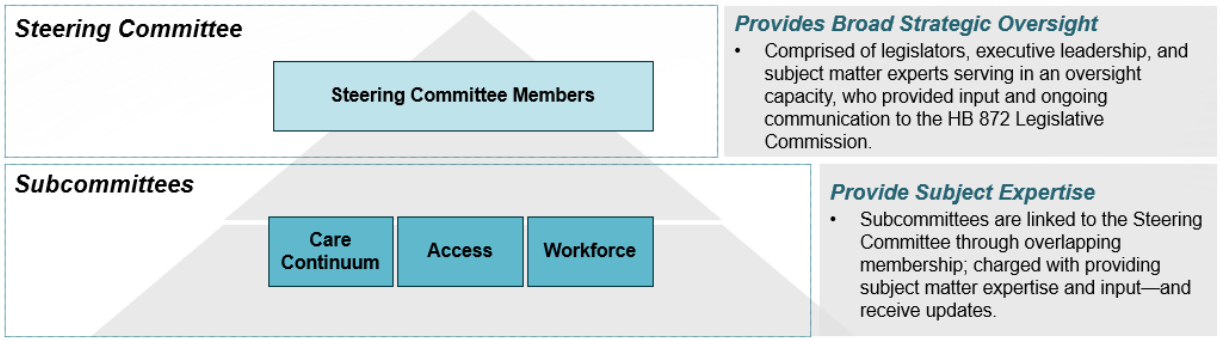


Figure 6. Steering Committee and Subcommittee Reporting Relationship and Organization

Steering and Subcommittee Committee Structure

DPHHS identified Subcommittee members to be included in the Steering Committee to provide strategic guidance throughout the design study and implementation planning phases. A full list of Steering Committee and Subcommittee members is included in Appendix G.

The Steering Committee specifically focused on:

- Identifying promising and best practice approaches for enhancing BH and I/DD programs and settings,
- Sharing strategies that could reduce over-dependence on institutional and state-run facility settings, and
- Identifying suitable alternative and community-based treatment settings.

The engagement process for the Steering Committee and Subcommittees was constructed to promote statewide collaboration. The study team engaged with the Subcommittees during four rounds of meetings, broken out across three regions to fully harness subject matter expertise and gain insights to further understand BH in Montana. After each round of Subcommittee meetings, the study team convened with the Steering Committee to discuss and synthesize the Subcommittee's feedback. The meeting sequence fostered a consistent understanding of information gathered, which guided the study team during the assessment phase and aided developing recommendations.

Subcommittees play a crucial role within the design study, as they are intricately linked to the Steering Committee through shared membership, tasked with offering specialized subject

matter insights. Figure 7 explains each BH Subcommittee's primary focus areas and resulting implications for setting design.

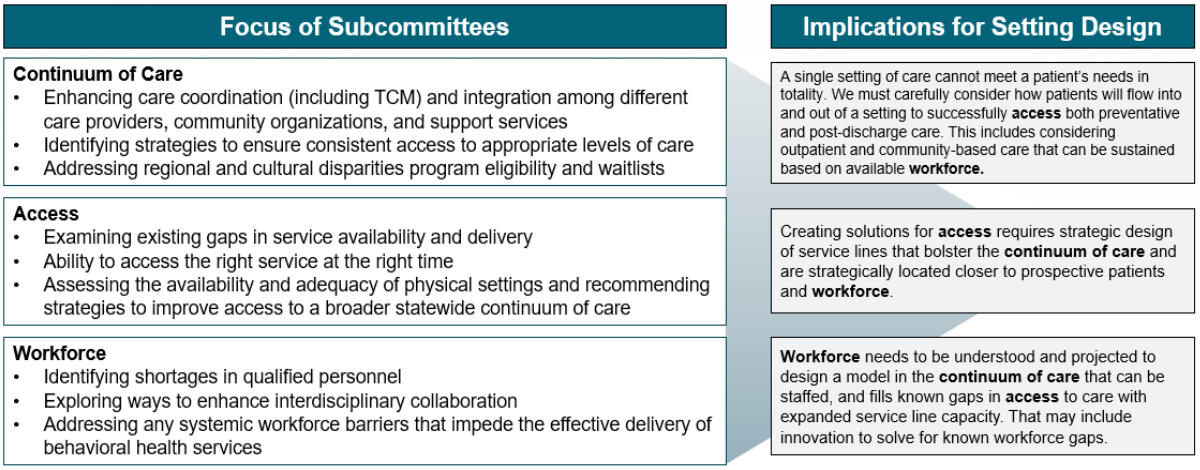


Figure 7. Focus of Workforce, Access, and Continuum of Care Subcommittees

Stakeholder Engagement: Quantitative and Qualitative Data Sources

The study team conducted stakeholder engagement activities to gather extensive data on demographics, historical usage, and stakeholder perspectives. Next, the study team focused on extracting data insights to shape recommendations. Each data point, be it a demographic trend or a nuanced stakeholder observation, served as a distinct lens through which Montana's BH and I/DD delivery system can be measured and understood. (In order to thoroughly consider I/DD community needs in Montana, a separate report is focused on analysis and recommendations for the I/DD system.) This data-driven analysis formed the foundation for establishing actionable recommendations that offer anticipated benefit to the State.

In collaboration with DPHHS, the study team conducted public meetings, interviews, listening sessions, and other stakeholder engagement activities from August 2023 through January 2024. Meeting recordings are accessible on the DPHHS website for public reference.[3] Formal stakeholder engagement efforts are described below.

1. **Steering Committee:** The Steering Committee provided broad strategic oversight and included experts and leaders across the behavioral healthcare continuum in Montana. The Steering Committee met four times to synthesize information gathered from the Subcommittee meetings to strategically advise the design study and implementation planning. The Steering Committee had the specific goal of distinguishing the unique needs of pediatrics and adults with mental health (MH) conditions, SUD, I/DD, and co-occurring conditions.
2. **Subcommittees:** The three Subcommittees - Continuum of Care, Access, and Workforce - added subject matter expertise to stakeholder discussions and helped inform the recommendations. These Subcommittees included a broad array of providers, advocates, cross-sector partners, and individuals with lived experience. The focus of each Subcommittee and their overall implications and impact on the design study are illustrated in Figure 7 with additional detail provided below.

[3] "BHDD Alternative Settings Project," 2023, https://dphhs.mt.gov/futuregenerations/bhddalternativesettingsproject.

a) The **Continuum of Care Subcommittee** reviewed relevant data analytics to provide feedback and discussed crucial gaps in Montana's behavioral healthcare continuum, including regional and cultural disparities, program eligibility, and waitlist concerns. In September and October 2023, the study team divided the Continuum of Care Subcommittee further into three regional groups – west, north, and east/south – for focused geographical consideration and feedback.

b) The **Access Subcommittee** reviewed relevant data analytics to consider challenges that impede individuals' access to care in Montana. The Access Subcommittee focused on individuals receiving the right services at the right time and how to optimize service programs and physical care settings to improve availability and adequacy across the State. The Access Subcommittee was divided into three regional groups – west, north, and east/south – for focused geographical consideration and feedback.

c) The **Workforce Subcommittee** reviewed relevant data analytics regarding Montana's current BH workforce to inform understanding of shortages in qualified personnel, systemic workforce barriers, and strategies for recruitment, retention, and necessary workforce development.

3. **National Alliance on Mental Illness (NAMI) Montana Annual Conference:** On October 26, 2023, in coordination with NAMI Montana, the study team and DPHHS staff facilitated over five hours of focus groups with more than 50 individuals and families, with lived experience pursuing BH services in the State, and conducted more than six hours of virtual meetings to engage individuals who were not able to attend the focus group sessions. This input provided the study team with an additional opportunity to learn about the specific needs and perspectives of those with lived experience.

4. **Tribal Community Meetings:** Tribal communities are a significant part of the State's population. Considering each distinct Tribal nation along with their unique identities and cultures, required targeted engagement to understand their distinct perspectives. To learn about Tribal community-specific needs and perspectives, the study team attended and facilitated Tribal community meetings, with both individual tribes and combined Tribal leaders.

5. **Montana State Government Listening Sessions:** To understand the perspective and priorities of Montana State government officials overseeing Medicaid administration and BH across the State, the study team conducted one-on-one listening sessions with key DPHHS officials in the Director's Office, Medicaid and Health Services Branch, Behavioral Health and Developmental Disabilities Division, and Child and Family Services Division. The depth of one-on-one sessions with these subject matter experts broadened the knowledge base of the study team to develop recommendations relevant to the needs of Montanans.

6. **Key External Stakeholder Interviews:** To understand BH continuum factors and performance throughout Montana, the study team interviewed subject matter experts identified by DPHHS and the Steering Committee. The diversity of the identified interviewees promoted representation across all areas of the State and spanned experts from various sectors, including providers, community-based organizations, non-profit leaders, and individuals representing lived BH experiences.

Data Analysis Methodology

The study team used various data sources to develop a comprehensive understanding of Montana's BH resources to measure service demand across the State. The study team analyzed both quantitative and qualitative data. When analyzing quantitative data, the study team applied qualitative data captured from interviews and best practice research to holistically evaluate Montana's BH system. This holistic approach allowed the study team to deepen our understanding of the factors that drive regional variations in service needs and utilization, to identify potential gaps in the continuum of care, and identify strategies most likely to strengthen Montana's BH service delivery system.

The study team applied a series of analytical methods shown in Table 1 to examine Montana's BH services and trends in service usage. Identifying trends helped the study team understand the current state of BH in Montana and inform where services are most needed.

Table 1. Applied Data Analytics Methods

Analytical Methods	Description of Method
Data Analysis	Perform descriptive and inferential analyses on data from multiple sources to identify patterns, trends, and regional variations in service utilization, needs, and gaps.
Thematic Analysis	Analyze Steering Committee, Subcommittee, and stakeholder interview data to identify key themes and perspectives on Montana's BH service delivery system.
Mapping and Geospatial Analysis	Utilize geographic information systems to map service availability, utilization patterns, and potential service gaps across Montana's regions.
Comparative Analysis	Compare Montana's BH ecosystem with best practices and models from other states identified through benchmarking resources.
Gap Analysis	Identify gaps in the current service continuum across regions and acuity levels, based on available data and stakeholder insights.
Synthesis and Recommendations	Synthesize findings from various data sources and analyses to develop recommendations for alternative service delivery models that address identified gaps and improve BH service access in Montana.

Data Collection: Quantitative Data Sources

The study team leveraged a diverse array of sources for gathering information and insights into Montana and its BH system. Outlined below are the data sources used as well as a brief description of each.

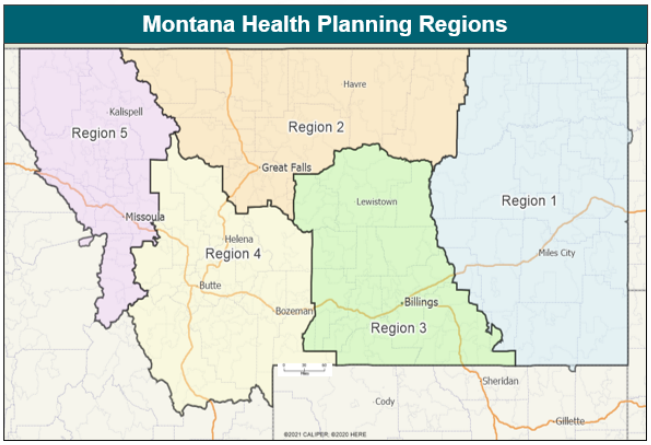
1. **Population and demographic data**: The study team utilized data from the Environmental Systems Research Institute (ESRI©)[4] and Claritas to evaluate size and demographics of population in Montana's five health planning regions, to aid in assessing the magnitude of BH and I/DD services needed across Montana's regions.
2. **Inpatient (IP) hospital discharges:** The study team utilized data provided by DPHHS, sourced from the Montana Hospital Association to assess historical demand for acute

[4] ESRI utilizes the 2020 US Census as a baseline and integrates updates primarily from the US Census Bureau American Community Surveys (ACS). Any forecasting and value-add data not directly sourced from the US Census Bureau are internally developed by ESRI.

(IP) BH and I/DD services.

3. **Management Information and Cost Recovery System** (**MICRS) State facilities data:** The study team used MICRS data to understand the role of Montana's state facilities in addressing the needs of individuals living with BH issues and/or I/DD, evaluating where patients visiting state facilities originate to determine the degree of outmigration for BH and I/DD care for individuals. The study team also used MICRS data to determine the variability in service utilization by individuals across health planning regions and identify potential service gaps in the behavioral healthcare continuum.
4. **Medicaid Management Information System (MMIS) Medicaid claims data:** MMIS data was applied to assess variations in how Medicaid enrollees utilized BH and I/DD services across the regions, identifying potential gaps, and to quantify space required to support current behavioral healthcare utilization by the Medicaid population.
5. **Proprietary Guidehouse data sets:** The study team utilized various data sources to build a more comprehensive understanding of the population, the BH and I/DD delivery system in Montana, and peer / comparison states. The proprietary data sources include the following:
    a) InSight™ Health – InSight™ Health is a Guidehouse-developed data solution that warehouses a wide variety of publicly available data regarding population health and demographics. The study team used this solution-set to measure social determinants of health (SDoH) factors impacting Montanans.
    b) Definitive Healthcare – Definitive Healthcare is a healthcare intelligence platform that provides comprehensive data and analytics on the healthcare industry. The study team leveraged the Definitive Healthcare platform to generate lists of BH and I/DD providers in Montana and other comparison states and profiles of psychiatric facilities.
    c) Clarivate – Clarivate provides insights, analytics, and solutions across various domains including healthcare. The study team utilized Clarivate to estimate the Medicaid population in each Montana zip code.
    d) Care Journey – Care Journey is a healthcare analytics company that specializes in providing insights derived from Medicare data to support organizations in improving individual outcomes and healthcare delivery. The study team leveraged Care Journey to measure BH utilization rates for Medicare and commercial populations when benchmarking Montana to utilization rates for other states.
6. **Comparative reference points:** The study team benchmarked Montana's BH and I/DD delivery systems against national standards using resources like the Substance Abuse and Mental Health Services Administration (SAMHSA), NAMI, and the Rural Health Information Hub to identify best practices from other states and programs.
7. **Ranking the states:** The study team utilized data from *Mental Health America* and *America's Health Rankings* to benchmark Montana BH delivery system against peer / comparison states.
8. **DPHHS Website and State government sites:** The study team searched the DPHHS website and websites of other states to gather information on existing BH service models, program initiatives, and policies that could be adapted for Montana.

The study team used Montana's five health planning regions[5] as established by DPHHS to guide the design study. Figure 8 maps each health planning region with county-to-region assignment. Each region has unique geographic and demographic attributes, which were individually analyzed in the design study. Regional segmentation supported measurement of the differences in BH services across the State. Regional measurement was a principal factor to establish recommendations aimed at addressing identified gaps that vary by region.



Region	Counties
Region 1	Sheridan, Daniels, Valley, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River, and Carter
Region 2	Blaine, Hill, Liberty, Toole, Glacier, Phillips, Pondera, Teton, Chouteau, and Cascade
Region 3	Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn
Region 4	Lewis and Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park, Gallatin, Madison, and Beaverhead
Region 5	Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli

Figure 8. Montana Health Planning Regions

Best Practice Research

The study team's analyzed best practices implemented in peer / comparison states and nationally. The study team considered what could feasibly be adapted and implemented in Montana given the lack of providers, rurality, and sparse population throughout much of the State.

The purpose of this research was two-fold: 1) to understand Montana's BH delivery system in relation to peer states based on geographic and demographic characteristics; and 2) to inform recommendations based on best practices and innovative programs from the peer comparison states.

State-Level Policy Research

The study team researched state government webpages and reports, national and state-level news, and Medicaid program design and outcomes to develop comparative summaries of peer states to the Montana BH system.

In addition to peer states, the study team also researched the design components and measurable outcomes of states who had incorporated innovation specifically related to challenges stakeholders conveyed regarding Montana (e.g., geographical diversity, rurality, etc.). The combination of insights gleaned from states like Montana and those with notable innovations offer a comprehensive basis for consideration for Montana. Table 2 provides explanations for further understanding of state-level comparative factors used to identify and compare Montana to other states' systems.

[5] "Health Planning Regions," n.d., https://dphhs.mt.gov/qad/licensure/healthcarefacilitylicensure/certificateofneed/healthplanningregions.

Table 2. Explanations of State Comparisons and Models

Comparison and State Models	Explanation
Peer States Wyoming, South Dakota, North Dakota, and Oregon	Peer states were selected based on comparative factors of similarity including geographical diverseness and breadth of rural and frontier populations, to promote the most appropriate and meaningful comparison to Montana.
ACO State Models Colorado, Minnesota, and Oregon	States with Accountable Care Organization (ACO) models were identified using a process aimed at identifying models that Montana could potentially employ for healthcare improvement. States were chosen based on their established ACO frameworks, performance outcomes, and relevance to Montana's healthcare landscape. The selection process prioritized a comprehensive understanding of successful ACO implementations, allowing Montana to draw insights and strategies from states that demonstrated effective behavioral healthcare management.
Alternative State Models Alaska, Georgia, North Dakota, and South Dakota	States with alternative care models were identified based on having innovative approaches that could be adapted by Montana. The examination delved into the specific program structures, outcomes, and methodologies that helped to identify states, with the aim of extracting insights that could inform Montana-focused program strategies.

Review of National Standards and Benchmarks

The second component of best practice research included benchmarking Montana to national standards. This research included the review of academic publications, policy center reports, and federal agency recommendations. The study team conducted the research and developed recommendations for Montana based on national standards supported by experts in behavioral healthcare provision. Additionally, the study team reviewed the national landscape to inform Montana's understanding of country-wide priorities in behavioral healthcare. Based on the review, the study team determined Montana's priorities for improving the BH of its residents align with states across their region and the country at large.

Findings and Recommendations

The section provides detailed recommendations for the State. These recommendations are intended to improve access and enhance the care continuum of BH services for Montanans. Each recommendation includes a summary of the recommendation; information regarding the rationale, data, and best practices supporting the recommendation; a description of potential impacts and pitfalls; and anticipated next steps should the recommendation be considered for implementation.

The recommendations are categorized in three groups: Continuum of Care, Access, and Workforce. The study team evaluated each recommendation using the following six criterion and associated weighted influence (in parentheses):

- Broad BH system impact (35%)
- Subcommittee identified priorities (20%)
- Montana DPHHS investment commitment (15%)
- BHSFG Committee priority (10%)
- Implementation complexity (10%)
- Level of effort (10%)

The study team and DPHHS determined the weights for each criterion and then scored them based on the ability to impact behavioral healthcare within the State. The study team normalized recommendations relative to one another using a one-to-five Likert scale, with five being the most favorable and one being the least favorable. The maximum number of points that could be obtained per recommendation was 30 points.

If a recommendation received a total weighted score above 20 points for Care Continuum and above 18 points for Access and Workforce, the study team confirmed that recommendation as a key initial priority. The study team conducted this relative scoring exercise to help identify no-regret strategies and priority initiatives. The study team suggests the State consider future implementation for recommendations ranked below the stated threshold (i.e., secondary order recommendation). The secondary order recommendations are described in Appendix E. Second-Tier Recommendations.

The study team conducted this qualitative and quantitative ranking exercise to help prioritize and identify which recommendations should be an initial area of focus for Montana, based on identified need and broadest impact and given the finite financial resources to improve behavioral healthcare.

1. Continuum of Care Priorities

The study team recommends that Montana pursue a statewide system that offers a standard approach to comprehensive care management for individuals across all areas of the State. Based upon discussions with the Steering Committee and DPHHS, the study team acknowledges that a managed care-driven approach may not be the right fit for the State. At the very least, it is understood that a capitated managed care approach was not successful in

advancing the BH system in the past, although this past failure should not restrict appropriate consideration of similar models that may now work for the State of Montana.[6]

As an alternative way to implement comprehensive care management, the study team recommends that Montana build upon existing primary care integration efforts. Additionally, the State is advancing CCHBCs, a modern SAMHSA-funded approach that centralizes a comprehensive package of OP behavioral healthcare, including primary care screening. These initiatives could be intersected using a Medicaid primary care case management (PCCM) approach that would introduce a governing Medicaid program that fosters statewide consistency in care delivery, outcomes measurement, oversight, and operational standards, to promote a high quality of care management throughout the State.

PCCM is used in states to deliver a single "health home" often to high-risk, high-cost individuals who need intensive, coordinated support. The study team suggests this approach is appropriate to do the following: 1. build upon existing capacity and momentum while 2. introducing overarching infrastructure that better links the continuum of care to encourage desirable care flows that minimize avoidable acute and crisis care while maximizing preventative and routine care. A PCCM approach would also foster localized implementation, which is important to stakeholders who noted the closeness and individuality of communities throughout the State.

The study team suggests expanding PCCM models to incorporate BH provisions and qualify more individuals. Care management teams in local regions would ideally include a care team comprised of medical, therapeutic, and social work experts. Optimally, the care management team would expand their network by utilizing extenders, such as community health workers and peer support specialists, who have fledgling networks throughout the State.

Beyond the PCCM approach, the study team recommends the State consider the role of an Administrative Services Organization (ASO) as a potential way to fill gaps in technological, data, and reporting infrastructures, which stakeholders report as a widespread challenge. ASOs are a contractor type organization that can deliver administrative and other operating functions individual providers may not be able to self-fund and/or should be implemented with a uniform system that allows for cross-network interoperability. States such as Alaska and Connecticut, who have elected not to move to at-risk, capitated managed models, have procured ASOs to add needed infrastructure, develop and organize provider networks, and support other functions like call centers and other customer service functions that further enhance care management models.

Figure 9. Continuum of Care Recommendations ScorecardFigure 9 lists key initial **Continuum of Care** recommendations with criteria weighting assignments and resulting priority scores.

[6] Sue O'Connell, "Montana's History With Managed Mental Health Care," *Montana Legislature*, October 2008, https://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/mhmanagedcarebackground.pdf.

Recommendations	Broad BH Ecosystem Impact	Subcommittee Priority	Investment Commitment	BHSFG Commission Priority	Implementation Complexity	Level of Effort	Initial Score
1.1 Develop a statewide comprehensive care management role or entity to facilitate care coordination between participants in Montana's BH system.	High	High	$$$$	High	High	High	22
1.2 Enhance existing infrastructure and resources – for example CCBHC, mobile crisis, PACT/ACT, school-based programs with sustained funding.	Moderate	Moderate	$$$	Moderate	Low	Moderate	21
1.3 Incorporate culturally relevant care protocols (Tribal and others) and hire culturally relevant staff.	Moderate	Moderate	$	Moderate	Low	Moderate	21
1.4 Expand use of integrated behavioral care models to support collaboration through partnerships with BH providers, enhanced reimbursement, and training.	High	Moderate	$$$	High	High	Moderate	21
1.5 Spread awareness of Medicaid reimbursement for mobile crisis services (recent State Plan Amendment) to encourage its expanded utilization.	Moderate	Low	$	Moderate	Low	Low	20

Figure 9. Continuum of Care Recommendations Scorecard

Recommendation 1.1. Develop a statewide comprehensive care management role or entity to facilitate care coordination between participants in Montana's BH system.

Montana's current BH system is fragmented, which hinders coordination among providers, individuals, and their caregivers. To address this, a proposed solution involves agnostic care managers within a dedicated entity, or entities, to enhance seamless care coordination. The State could create the care management role through several different approaches, such as directly hiring care managers or contracting with a third-party entity that provides care management services. If contracting with a third-party entity, the State can use Montana's procurement process to identify qualified entities adept at providing longitudinal care management services. This care management role would serve as a centralized accountable hub to coordinate all care for eligible individuals who have complex care needs. The study team recommends that the State define the population eligible for these new care management services as those with serious mental illness (SMI) and serious emotional disturbance (SED) and those who have had a recent IP stay for a BH diagnosis, or a subset of these populations.[7] To avoid duplication of services and payment for case management services, individuals receiving Medicaid management (TCM) would not be eligible to receive services from the comprehensive care manager role or entity.

To be successful, the care management role would use information technology tools (e.g., bed registry) to track bed availability real-time statewide to help identify facilities with available capacity, as well as coordinate other resources on behalf of the individual. A care management role or entity represents a longer-term solution and would take three to five years to implement.

Currently, care managers exist in multiple settings including IP settings, CCBHCs, the Intensive Behavior Center (IBC), residential treatment centers, OP facilities, and forensic hospitals. However, there is not one single designated care manager that individuals work with on a regular basis who knows their history and cares for them over multiple years. Communication issues across treatment settings could be alleviated by these proposed care managers, fostering unified communication across care levels and stakeholders. Recognizing limited behavioral healthcare navigation support, care managers are suggested to provide personalized guidance, scheduling assistance, and advocacy, particularly for complex care needs.

Additionally, care managers play a pivotal role in optimizing resource utilization, preventing duplicated services, and addressing gaps in care. A comprehensive care manager role or entity can support individuals to receive services in the most appropriate setting and assist individuals to transition out of state-run facilities, such as MSH, in a timely manner, coordinating with other members of the care team.

Factors Supporting the Recommendation

- **Fragmented healthcare system**: The behavioral healthcare system is measurably fragmented and thus hard to navigate. Providers, individuals receiving care, and caregivers must coordinate services in multiple settings, with various providers, across disparate information streams. A dedicated care management role that coordinates with the entire provider network and BH system can bridge these gaps and foster seamless care coordination.

[7] SMI and SED include the following diagnosis categories: schizophrenia, schizotypal, delusional, other non-mood psychotic disorders, manic episode, bipolar disorder, depressive episode, major depressive disorder, persistent mood (affective) disorders.

- **Disjointed communication and collaboration**: Communication and coordination of care is siloed within the treatment setting. The NAMI focus group and Subcommittee members indicated that a comprehensive span of control among care managers could facilitate communication between different sites and acuity levels of care, BH providers, medical practitioners, individuals receiving care, and families, creating a more unified approach to supporting and building a rapport with individuals.
- **Limited behavioral healthcare navigation support**: Scheduling, identifying available services, and ensuring compliance with care plans is currently the responsibility of the individual receiving care and/or their caregivers. These tasks can prove highly challenging when individuals have BH needs or circumstances that render them limited in their ability to execute. Additionally, many individuals lack expertise needed to navigate a complex BH system with an array of providers, often spanning multiple regions of the State. Comprehensive care managers can provide personalized guidance, support, assistance with scheduling and appointment follow-up reminders, and advocacy to help individuals access appropriate services and avoid unnecessary prolonged stays in state-run facilities. Assigning individuals to care managers can also help with continuity and knowledge of lived experiences.
- **Duplicated services and gaps in care**: Service delivery can be duplicative, and in certain instances, results in safety concerns if medication and treatment are not coordinated. Resource utilization can be optimized by care managers coordinating care plans and preventing unnecessary duplication of services resulting in improved cost-effectiveness.
- **Underutilized facility resources**: Additional capacity exists for individuals with BH conditions in certain regions but there is no existing mechanism to easily track availability of beds or provider panel capacity. Using information technology tools (e.g., bed registry) to track bed availability real-time statewide allows care managers to help identify facilities with available capacity, streamlining individual care, minimizing wait times, and supporting patients to transition from state-run facilities when appropriate.

Quantitative Data that Informed the Recommendation

- **Montana has a higher number of behavioral healthcare sites than other states but that is not enough to resolve access gaps.** Per analysis, in terms of intermediate and OP care, Montana presently has a sizable number of care sites as listed in Table 3, with more sites than comparable states. However, the State's expansive geography poses challenges to effectively delivering these services within a reasonable drive-time based on the acuity of the individual receiving care. A comprehensive care management role can enhance care coordination to identify where real-time capacity exists within the closest proximity to the individual.

Table 3. State BH Locations per 100k Persons by State[8,9,10]

Behavioral Healthcare Settings	MT	ND	SD	WI
IP	0.9	1.0	1.5	1.0
Partial Hospitalization	1.1	2.5	0.6	0.7
Residential	2.8	3.2	2.4	0.6
OP SUD	10.5	7.0	6.4	4.4
OP MHC	2.7	1.9	2.4	2.8
Intensive OP	4.0	3.6	3.0	1.1
Multi-Setting	0.6	0.3	0.0	0.1

Lowest ***Highest***

Table Note: Table 3 shows average care settings per capita multiplied by 100,000. Site counts are based on count of unique addresses in SAMHSA's database. A site may be represented across multiple care settings if it offers relevant services for the category. Other care settings are not shown due to lack of data. behavioral healthcare setting definitions can be found in Table 14 in Appendix B.

When comparing the prevalence of BH conditions in Montana to demographically and geographically similar states, Montana stands out as having the third-highest national suicide rate, one of the highest rates of SUD, and a significant number of pediatrics with BH diagnoses, (as shown in Table 12 in Appendix B). While acknowledging the limitations in state comparison metrics, Montana's relative performance suggests that Montana's BH system is not presently equipped to meet the population's need for behavioral healthcare. A comprehensive care management role can improve the system's functionality through enhanced overall coordination and improved organization and monitoring of provider capacity to support timely provider linkages and access to specific types of behavioral healthcare.

Qualitative Data that Informed the Recommendation

Based on extensive stakeholder engagement, a resounding theme emerged in our research: individuals are struggling with fragmented care coordination. Many individuals receiving behavioral healthcare report having numerous care managers, each operating in silos with limited communication and information sharing. These care managers are often site-specific and employed by the specific site where an individual received care. Individuals and families receiving BH services expressed the need for a more seamless process, where they have one point of contact, who is familiar with them and their specific needs, across the entire BH system regardless of what setting(s) they receive care at. The current disjointed approach creates confusion, frustration, and hinders positive health outcomes as individuals struggle to navigate their care journey.

[8] "Behavioral Health Workforce Tracker," Data set, *Fitzhugh Mullan Institute for Health Workforce Equity*, n.d., https://www.gwhwi.org/behavioralhealth-workforce-tracker-v20.html.

[9] "National Directory of Mental Health Treatment Facilities 2021," *Substance Abuse and Mental Health Services Administration (SAMHSA)* (SAMHSA, April 2021), https://www.samhsa.gov/data/sites/default/files/reports/rpt34657/National_Directory_MH_facilities_2021.pdf.

[10] "National Directory of Drug and Alcohol Abuse Treatment Facilities 2022," *Substance Abuse and Mental Health Services Administration (SAMHSA)* (SAMHSA, April 2022), https://www.samhsa.gov/data/sites/default/files/reports/rpt35993/SA%20facilites/SU%20Directory/National_Directory_SA_facilities_final_04272022.pdf

Stakeholders overwhelmingly expressed the need for a centralized approach to care management that comprehensively spans the full continuum of care, including community-based access, to navigate the complexities of Montana's healthcare system. A comprehensive care manager would serve as a single point of contact, working in the best interest of the individual, ensuring seamless communication and collaboration between all care providers involved.

Anticipated Impact of the Recommendation

- **Improved health outcomes**: Well-coordinated care can lead to earlier intervention, improved adherence to treatment plans, and better physical and BH outcomes for individuals with BH needs.
- **Reduced utilization of expensive services**: Efficiently navigating the system can reduce the likelihood of avoidable emergency department (ED) visits, hospitalizations, and other high-cost interventions, including unnecessary prolonged stays at state-run facilities.
- **Increased individual satisfaction and empowerment**: Individuals accessing behavioral healthcare may benefit from personalized support and proactive care management, which can result in greater satisfaction with the healthcare experience and stronger engagement in their care and self-management.
- **Enhanced rapport between individual and care manager**: Individuals build a strong rapport with their care manager, regardless of which setting is accessed, which increases continuity in care. Comprehensive care managers with deepened understanding of an individual's needs, strengths, and personal preferences are better equipped to assist the individual in navigating the system, addressing barriers in care, and maintaining needed long-term treatment and engagement in care.
- **Strengthened community quality of life**: Improving access to high-quality behavioral healthcare leads to improved individual quality of life, that, in aggregate leads to community-wide improved quality of life.

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above.

- **Workforce availability and training**: Establishing a statewide care manager network requires a network of qualified professionals. Recruitment, training, and retention strategies are crucial in this respect. Potential implementation options to bolster an accessible professional network include expanding the training available at state universities to train emerging professionals on care management best practices and/or developing a train-the-trainer program through existing care managers in the State.
- **Impact on TCM**: Although this recommendation is focused on providing care management to individuals who are not receiving Medicaid TCM, there is the potential the recommendation could have indirect impacts on TCM services. For example, stakeholders expressed that rate reductions have impacted the quality of TCM services and the "brain drain" of experienced case managers who left the network for other positions. In addition, the State would need to ensure that there is no duplication of services between the comprehensive care manager role or entity and Medicaid TCM.

- **Funding and sustainability**: Implementing and maintaining a statewide care manager program requires sustained funding. Exploring innovative financing models and seeking public-private partnerships will be vital.
- **Supporting IT systems and analytics**: An IT system that monitors real-time BH bed availability and maintains an updated inventory of state-wide and community-specific resources is essential to comprehensive care management. These electronic inventories are essential to equip care managers with accurate understanding of access points that facilitate timely placement and coordinated management throughout an individual's episode of care.
- **Integration with existing infrastructure**: Ensuring seamless integration of care managers within the existing healthcare system and building data exchange platforms for monitoring individual care is essential to avoid duplicating efforts (including with TCM) and creating additional silos, as well as for monitoring performance.
- **Addressing confidentiality and privacy concerns**: Building trust and adhering to strict confidentiality standards is crucial to ensure care managers have protocols to follow that protect protected health information when working with interdisciplinary care teams and the broader network of behavioral healthcare providers.

Recommended Next Steps

- Develop a clear framework for the care management role, outlining responsibilities, qualifications, training needs, and conflict of interest considerations. The care management role offers a unified point of contact for individuals across the care continuum. By accessing a new State database, care managers gain insight into bed inventory and facility resources, facilitating continuous support for individuals. For care managers to be effective in their role, IT infrastructure must be in place to allow care managers to identify available resources.
- Determine the approach to deliver comprehensive care management services (e.g., directly hire care managers or contract with a third-party entity that provides care management services). If procuring a third-party entity, follow Montana's procurement process to explore partnership opportunities with existing or new organizations, which would most likely be a public-private partnership, to leverage resources and expertise in building the care manager network.
- Secure sustainable funding through a combination of state, federal, and private sources, advocating for policy changes that support care management models.
- Implement pilot programs in targeted areas to assess the feasibility and effectiveness of the statewide care management model before broader rollout.
- Identify dashboard metrics to be housed in the care management IT system to measure the success of the program (e.g., higher occupancy rates, shorter wait times to appointment, frequency of follow-up appointments scheduled, etc.).
- Develop robust data governance policies and privacy protocols for secure information exchange and patient confidentiality.

Recommendation 1.2. Enhance existing infrastructure and resources – for example CCBHC, mobile crisis, PACT/ACT, school-based programs with sustained funding.

Montana stakeholders and DPHHS leaders are actively pursuing initiatives and programs aimed at strengthening the State's BH system. In review of ongoing program development, several

initiatives stood out as promising current initiatives with the potential to address the key challenges revealed in the analytical work of the design study.

CCBHCs, mobile crisis teams, Patient Aligned Care Team (PACT)/Aligned Care Team (ACT), and school-based MH initiatives each address specific vulnerable populations and specialized care needs across the State. The study team recommends sustained implementation of these initiatives, coupled with securing sustainable funding and administrative structures to permanently advance each initiative in a way that is scalable, adequately funded, and supported with regulatory, policy, and program administrative structures to allow DPHHS to effectively administer and advance emergent BH models of care that are new and innovative.

- **CCBHCs** provide comprehensive, OP behavioral healthcare, upheld to national quality standards, to support individuals with BH diagnoses to receive effective care and treatment while remaining in their communities. The study team recommends that the State allocate funding for the net new costs associated with implementing CCBHCs and explore opportunities to expand the number of CCBHCs beyond the 4-year demonstration period and in future years.
- When discussing effective treatment programs in Montana, stakeholders regularly report **mobile crisis** teams and **PACT/ACT** teams are a strong model for community-based treatment. Mobile crisis teams are also relevant to statewide prevention delivery in rural and frontier areas and are a priority area for effective treatment of individuals with urgent needs to prevent escalation. The study team recommends that the State offer mobile crisis services in rural and frontier areas of the State. This may require the development of varied care delivery options based on population density, such as in-person mobile crisis teams in urban areas and virtual mobile crisis teams in areas of lower population density. The study team also recommends that the State assess payment options that will allow for broader delivery of mobile crisis services, such as on-call funding for teams in areas of lower population density. Payment options would be designed to both develop and sustain the delivery of mobile crisis services.
- The prevalence of BH conditions among the pediatric population and limited-service access stands out in data analytics as a stark challenge in Montana. **School-based service expansion** can reach the pediatric population through existing community infrastructure. The study team recommends that Montana allow school districts to bill for Medicaid services without regard to an Individualized Education Plan, and that the State invest in exploring other school-based MH services.

Factors Supporting the Recommendation

- **Leveraging existing strengths to swiftly intervene**: Building upon established programs allows for short-term impact while providing a buffer to address current State BH system gaps, while advancing long-term investments that will take time to stabilize the State's care continuum.
    - **CCBHCs**: DPHHS is actively executing a CCBHC Planning Grant, which ends in March 2024. Currently, there are four Cohort 1 providers ready to pursue certification and prospectively engage in a statewide CCBHC program, a process being overseen by DPHHS.
        - The four providers are all located in separate health planning regions, Regions 1, 2, 3, and 5. Notably, the combined regional population for

potential impact amounts to approximately 797,143 persons.[11] Should Montana receive the CCBHC Demonstration Grant, there will be a meaningful opportunity to lay the foundation for systematic, comprehensive community-based behavioral healthcare.

        - With four key BH providers participating, and others interested, CCBHCs have the potential to become a state standard-bearer for high quality, comprehensive quality BH services to serve individuals with complex care needs.
    - **Mobile Crisis Units**: The recent approval of the Medicaid State Plan Amendment for Mobile Crisis Units in Montana opens the door for service expansion in this space, via expanded reimbursement infrastructure. Mobile Crisis Units offer flexibility to offer services in communities in the State where there is not sufficient population to sustain brick and mortar care sites.
    - **PACT/ACT Teams**: Montana Medicaid currently reimburses PACT/ACT teams. Stakeholders regularly noted these programs are effective community-based treatment for individuals diagnosed with SMI who need management and support.
    - **School-based Mental Health Initiatives**: Stakeholders reported school-based MH programs and supports have experienced funding fluctuations in recent years, destabilizing the efficacy of programs that are high-impact as they are co-located to community anchors (schools) where the pediatric population and their parents are easily accessible on a highly routine basis. In recent years, because of funding and policy changes in 2020, Montana schools have increasingly been responsible for budgeting for MH programs for the pediatric population. Without new, sustainable funding sources, or the revocation of the free-care rule that allows schools to bill for Medicaid services, it will be difficult to meet the demand for school-based services. Establishing policies and reimbursement for school-based MH programs would allow for historically successful programs to be reinstated and expanded.

- **Maximizing resource utilization**: Enhancing existing infrastructure maximizes the return on investment from previously allocated resources, which can promote cost-effectiveness and sustainability.
- **Filling service gaps**: Strengthening existing programs can address current gaps in BH access, particularly in rural and frontier areas, Tribal lands, and for underserved populations. Further, strengthening existing programs can help connect individuals to BH services while BH conditions are still mild to moderate, helping prevent the need for higher intensity services, such as services provided by state-run facilities.
- **Promoting continuity and integration**: Investing in existing programs can foster continuity of care and facilitate improved integration within broader healthcare systems.

Qualitative Data that Informed the Recommendation

- Stakeholder feedback clearly emphasized the importance of leveraging existing community-based resources to improve BH services, particularly for the pediatric population and early intervention and prevention. Information shared in the *Factors Supporting the Recommendation,* is a direct reflection of stakeholder perspective and

[11] DPHHS Website, ESRI Data 2022-2027

impacts of similar programs and services being deployed in states throughout the country.

Anticipated Impact of the Recommendation

- **Increased access to care**: CCBHCs, mobile crisis teams, PACT/ACT, and school-based MH programs can significantly expand access to BH services for individuals of all ages and backgrounds. Mobile crisis teams and school-based MH programs would be particularly beneficial for Tribal lands and in rural and frontier communities. Transportation and internet connectivity is particularly challenging, and mobile services and telehealth allow for greater accessibility for those in need of BH services,
- **Added convenience and reliability:** Bringing services into the schools, either through telehealth or mobile units, can help resolve several issues, particularly in rural, frontier, and Tribal communities, which include transportation to appointments, decreased reliance on parental support, consistency of care, and access to stable internet networks.
- **Improved early intervention and prevention**: Early access to BH services in schools and through mobile crisis teams can lead to earlier identification, reduced stigma, intervention for BH concerns, and potentially prevent escalation of physical health and BH conditions.
- **Reduced reliance on emergency services and state facilities**: Strong community based BH resources can decrease the utilization of EDs and IP care for BH crises, leading to cost savings and improved outcomes, as well as reduced reliance on state-run facilities.

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above.

- **Fragmentation of care**: Without careful coordination, enhanced programs can operate in silos, leading to fragmented care and potential overlap or gaps in services. However, the State can mitigate this risk by providing CCBHCs, schools, and mobile crisis sites with access to care coordination IT systems and care managers to assist the individuals they serve.
- **Workforce shortages and training needs**: Strengthening these programs will require additional qualified BH professionals, potentially exacerbating existing workforce shortages. Adequate training and recruitment strategies are crucial particularly in Tribal populations and with ethnic minorities. Recruitment plans outlined in Appendix F highlight specific initiatives to build a Tribal workforce from within through identification of high-performing high school and college students with supporting rural and underserved scholarship opportunities.
- **Sustainable funding challenges**: Long-term success hinges on securing sustained funding sources for services such as CCBHCs, mobile crisis teams, and school-based MH initiatives to ensure viability of programs. Diversifying funding streams and advocating for continued public and private support without gaps in funding is essential.

- **Equity and accessibility concerns**: Enhancements should promote equitable access for all populations, including rural, frontier, underserved, and Tribal communities. Addressing transportation barriers and cultural considerations is necessary.

Recommended Next Steps

- Develop a robust funding plan that secures sustainable resources through a combination of federal, state, and local funding sources, as well as innovative strategies like public-private partnerships. Examples of partnerships include Indian Health Services (IHS) and Food and Drug Administration (FDA) funding for mobile buses, Department of Education or SAMHSA funding for schools, CCBHC grants and permanent Medicaid reimbursement structures, and United States Department of Agriculture (USDA) funding.
- Invest in workforce development and training programs to attract and retain qualified BH professionals to staff enhanced programs, particularly in rural and frontier areas.
- Implement data-driven quality improvement measures and monitoring systems to track program effectiveness and inform ongoing adjustments and enhancements.
- Foster collaboration and coordination between various BH programs, healthcare providers, social services, and community organizations to promote integrated and seamless care delivery.

Recommendation 1.3. Incorporate culturally relevant care protocols (Tribal and others) and hire culturally relevant staff.

Culturally relevant BH entails health professionals understanding and respecting diverse cultural values, beliefs, and practices for individuals from all backgrounds. Various BH providers within Montana have begun steps to implement culturally relevant care. Culturally relevant care can improve quality by respecting diverse values and practices that maximize patient engagement and tailoring interventions to patients so that they are more likely to follow through with them. A culturally relevant approach typically drives toward addressing population health disparities to benefit minority and underserved populations with disproportionately high disease burden and historical disenfranchisement from formal healthcare.

Specific to Montana, expansions in culturally relevant care methods are essential to address the Tribal communities across Montana, who represent a sizable sub-population of BH care users who require cultural competence to maximize their care. To enhance care comprehensively, the recommendation emphasizes training new providers in culturally relevant practice, ongoing education in Tribal practices, and involving recognized Tribal leaders in the care delivery process, both on and off reservations. The Tribes and urban Indian organizations in Montana have worked together to advance a plan to providing new culturally informed BH service by creating a regional IP/residential healing center that would work collaboratively with existing Tribal and urban Indian BH programs to strengthen the State's continuum of BH services. This work has been supported with funding and technical assistance from the Montana Healthcare Foundation (MHCF). Additionally, the Montana Chemical Dependency Center (MCDC) is actively working on culturally relevant care inclusion by allowing common therapeutic practices observed by Tribal members (e.g., talking circles, smudging) and are seeking ways to merge culture into services. Additionally, Tribal members would like training and certification opportunities for providers working off the reservation to obtain cultural competency in Tribal practices. These courses could be designed through the IHS Clinical Support Center to be

eligible for continuing education credits to encourage participation in the classes. Funding would be needed to develop coursework materials, instructional time, and educational space.

Factors Supporting the Recommendation

- **Improved quality of care and patient outcomes**: Culturally relevant care recognizes and respects the unique values, beliefs, and healthcare practices of diverse communities, leading to more effective communication, trust, and engagement with healthcare services. A culturally relevant care approach can result in better diagnosis, treatment adherence, health outcomes, and patient satisfaction.
- **Addressing health disparities**: Addressing cultural differences in healthcare delivery can alleviate disparities in access, utilization, and quality of care experienced by minority and underserved populations, including Tribal communities in Montana. Tribal communities are recognized as having disproportionately high BH incidence rates and inter-generational trauma. Failure to proactively address these realities is a shortcoming in planning, as Tribal communities have measurably high needs that cannot be adequately addressed without culturally relevant care.
- **Strengthened community relationships**: Building trust and respect through culturally relevant care fosters positive relationships between healthcare providers and diverse communities, promoting collaboration and reducing cultural misunderstandings that lead to patient disengagement from care and/or unwillingness to access care.
- **Enhanced care on and off reservations**: Training all new providers in culturally relevant practice, developing on-going continuing education in culturally accepted Tribal practice, and incorporating recognized Tribal leaders in the care delivery process. The study team offers that members of Tribes do not exclusively seek care through Tribal health systems. Threading systems together to offer a sustained experience of care that is not episodically re-traumatizing to individuals is essential to design a BH system that addresses the needs and lived experience of Tribal members.
- **Parity in recognition of medical practices**: Reviewing State policies and procedures to ensure that they do not directly or indirectly disallow the inclusion of Tribal spiritual practices, like those of other western mainstream religions and facilitating appropriate access to those spiritual practices that also have therapeutic value for staff, patients and clients supports culturally relevant care.

Quantitative Data that Informed the Recommendation

- Native Americans make up approximately 7% of Montana's population, but they are disproportionately overrepresented in BH and SUD prevalence statistics. In 2023, American Indian or Alaskan Native (AI/AN) individuals made up 24% of opioid overdose cases[12] and, in 2021, 18.4% of opioid overdose deaths.[13] Additionally, the 2022 Behavioral Risk Factor Surveillance System (BRFSS), a national survey conducted annually by the CDC regarding health conditions, found that 26% of responding AI/AN

[12] Hannah Yang and Maureen Ward, "Montana 2023 EMS Data Report: Suspected Opioid Overdose," February 9, 2024, https://dphhs.mt.gov/assets/publichealth/EMSTS/Data/2023EMSOpioidOverdose.pdf.

[13] "Opioid Overdose Deaths by Race/Ethnicity | KFF," KFF, May 15, 2023, https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

respondents reported experiencing poor MH in more than 14 of the last 30 days, compared to the 15.5% of white respondents.[14]

- Figure 10 illustrates how Regions 1, 3, and 4 (especially Region 1: Eastern Montana) of the State are unique, having distinct geographic and demographic features including low population density, and high proportions of both Native American and Medicaid-enrolled residents. The demographic features of Regions 1, 3, and 4 must be carefully considered when designing strategies to improve access to BH services in these regions, which are more prone to facing challenges in this area.
- These factors collectively translate to a higher likelihood of individuals not having access to lower acuity preventative BH care and needing to travel longer distances to access acute services. Notably, Regions 1 and 2 have significant Native American populations. Therefore, it is critical that while addressing BH service needs in these regions, care providers incorporate culturally informed services and patient engagement practices that keep people in care. Additionally, it is imperative to partner with the Indian Health Service and the Tribal health system to maximize cross-partner alignment to foster network continuity in care practices.

2022 Service Area Demographics

Region/ Benchmark	Total Pop '22	Pop. CAGR '22-'27	Pop. Density / sq. mi.	Medicaid* N (% Pop.)	Disability** N (% Pop.)	Justice Sys.*** N (% Pop.)	% Native Am. N (% Pop)
Region 1	76,431	0.04%	1.8	**31.1%** (23.6K)	**14.7%** (11.3K)	**0.6%** (0.5K)	**14.1%** (10.7K)
Region 2	151,661	0.1%	5.2	**34.5%** (52.2K)	**13.9%** (21.1K)	**0.9%** (1.4K)	**16.0%** (24.3K)
Region 3	226,890	0.5%	8.3	**29.0%** (65.5K)	**12.6%** (28.6K)	**0.6%** (1.4K)	**7.4%** (16.9K)
Region 4	310,361	0.9%	10.8	**21.5%** (66.0K)	**12.2%** (37.8K)	**0.8%** (2.5K)	**1.4%** (4.4K)
Region 5	342,161	0.8%	17.9	**28.9%** (99.4K)	**15.0%** (51.3K)	**0.2%** (0.8K)	**3.7%** (12.8K)
Montana	1,107,504	0.6%	7.6	**27.8%** (306.8K)	**13.6%** (150.1K)	**0.6%** (6.6K)	**6.2%** (69.0K)
United States	335,707,897	0.2%	95.1	**28.3%** (94.8M)	**12.9%** (43.2M)	**0.6%** (2.1M)	**1.1%** (3.8M)

Significantly different from MT or US

Figure 10. Demographic Qualities and Characteristics by Region[15,16]

Figure Note: Percentages may be off slightly due to rounding. * Dual-eligibles are included in Medicaid data. ** Disability includes vision, hearing, cognitive, ambulatory, self-care, and independent living (2019). ***Justice Sys. Population in adult correctional and juvenile facilities (2020). N = 2022 population.

Qualitative Data that Informed the Recommendation

Stakeholder feedback, particularly from Tribal representatives, highlighted a critical gap in culturally relevant care within state-run facilities. This feedback is not a generalization of Tribal discussion, but rather, these were raised through discussions with individual Tribes. Their experiences underscore the urgent need for:

Culturally tailored services and accommodations

- All Tribal communities engaged expressed concern with the lack of services and accommodations that reflect their cultural values and practices. Relevant practices

[14] "BRFSS Prevalence & Trends Data | DPH | CDC," 2022, https://www.cdc.gov/brfss/brfssprevalence/index.html.

[15] DPHHS website, ESRI Data 2022-2027.

[16] "County Reports | Annual Disability Statistics Compendium," 2019, https://disabilitycompendium.org/county-reports.

include access to traditional healing methods like smudging and sweat lodges, which hold significant spiritual and therapeutic value.

  - Cultural integration does not simply acknowledge these practices, true integration requires a thoughtful understanding of the origin and therapeutic benefit of culturally relevant practices to meaningfully include traditional Tribal practices and customs into comprehensive care plans and person-centered interventions. If BH providers do not have this depth of understanding, they cannot incorporate these therapeutic approaches into treatment.

- The absence of Tribal-specific therapeutic options not only creates discomfort and a sense of alienation for Tribal individuals but also hinders their engagement with and utilization of BH services. For example, we heard that Tribal practices are important to Tribal communities and Tribal identity. These practices often include a spiritual element and many treatment centers do not incorporate Tribal practices, engendering mistrust and a perception of cultural dismissal that leads to care disengagement.

Culturally relevant staff

- Stakeholders emphasized the lack of knowledge and understanding of Tribal customs and traditions among many staff members at state-run and managed facilities. Lack of culturally relevant staff creates communication barriers, fosters mistrust, and impedes effective treatment and recovery.
- Culturally relevant staff, ideally employing representative individuals from diverse backgrounds in care settings, can build trust, improve culturally relevant care, and offer a point of advocacy and continuous provider education tailored to the specific needs of the communities being served.

Anticipated Impact of the Recommendation

- **Increased trust and utilization of healthcare services from trained staff**: Individuals from diverse communities are more likely to seek and engage in preventative care and follow treatment recommendations when they feel understood and respected by healthcare providers. The measurable outcome of this impact would be identified via care retention statistics, which indicate patients are routinely accessing care from consistent providers who they know and to whom they respond.
- **Improved disease management and prevention**: Culturally tailored interventions and education can address specific health needs and risk factors prevalent within diverse communities, leading to better disease management and prevention. Two such examples showing positive outcomes when culturally relevant care was delivered are the Special Diabetes Program for Indians and the adoption of the Community Health Representative Program.[17]
- **Reduced BH stigma and increased comfort with accessing BH services**: Cultural understanding can break down stigma surrounding MH and substance use issues in certain communities, encouraging individuals to seek help, access appropriate treatment, or harness their unique power. For example, the Tribal cultural world view is different and at times opposite from mainstream society; for example, someone with a "disability" is not seen as having a disability, they are seen as spiritually powerful.

[17] Kruse, Gina, Victor A. Lopez-Carmen, Anpotowin Jensen, Lakotah Hardie, and Thomas D. Sequist. "The Indian Health Service and American Indian/Alaska Native Health Outcomes." *Annual Review of Public Health* 43, no. 1 (April 5, 2022): 559–76. https://doi.org/10.1146/annurev-publhealth-052620-103633.

- **Enhanced community well-being**: Addressing cultural needs and health disparities within communities can contribute to overall well-being by improving individual health outcomes and fostering collective trust in the healthcare system. Numerous examples of how cultural traditions and healing methods can be adopted to improve Tribal behavioral and physical health are outlined through outcomes-based research. One such example of solutions was documented by the First Nations Behavioral Health Association located in Oklahoma.[18]

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana must ensure that unresolved risks do not hamper its efficacy in achieving anticipated outcomes above.

- **Retention of knowledge**: Without required continuing education programs being offered at regular intervals, retention of culturally relevant care and practices will not be automatic and a strategic, actionable plan with accountable partnerships will be essential to sustain continuing education for diverse communities of patients.
- **Resistance to change and resource limitations**: Implementing new protocols and hiring culturally relevant staff may result in resistance from some providers, and require additional provider resources, which can pose challenges for healthcare organizations with resource limitations. Targeted engagement and problem solving will be needed along with a continuous engagement of providers who may be skeptical or slow to adapt their practices.
- **Lack of continuous measurement:** The absence of continuous measurement of outcomes and accountability for BH population-specific improvement. Without ongoing attention and measurement of progress, there is a risk of inertia, hindering the identification of areas lacking improvement. The Commission's recommendation holds the potential to address this risk by emphasizing the importance of continuous measurement and accountability to aid in sustained progress.

Recommended Next Steps

- Use existing tribal forums or a new initiative led by the Office of American Indian Health to empower and unify Montana's Tribal nations. A diverse group of Tribal representatives, healthcare professionals, and elders would develop culturally relevant care protocols, training for non-Tribal providers, and advocate for policies that respect each Tribe's unique ancestral traditions and improve health outcomes for all.
    - Of note, at the request of Tribal Health Directors and Leaders, the Montana Healthcare Foundation is actively bringing communities and Tribal leaders together to create novel solutions for existing health problems.
- Develop culturally relevant care protocols based on community input and best practices, incorporating specific cultural considerations into clinical approaches and service delivery.
- Invest in training and education programs and roll-out the existing programs for healthcare providers to equip them with the knowledge and skills to deliver culturally relevant care.

[18] "FNBHA Catalogue of Effective Behavioral Health Practices for Tribal Communities." 2009. https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/a0004/first-nations-behavioral-health-association.pdf.

- Implement recruitment strategies and simultaneously build internal workforce within Montana that is culturally appropriate/relevant through focused efforts on promoting healthcare roles and funding education through IHS, National Health Service Corps, and others.
- Develop retention strategies that include identifying and educating residents of scholarships and grants, such as IHS and Health Resources and Services Administration (HRSA), who wish to improve themselves and provide care to their native communities. Foster ongoing partnerships with community organizations and Tribal leaders to collaborate on planning, implementing, and evaluating culturally relevant care initiatives.

Recommendation 1.4. Expand the use of integrated behavioral care models to support collaboration through partnerships with primary care and BH providers, enhanced reimbursement, and training.

Enhanced coordination among healthcare providers reduces the risks associated with fragmented care, contributing to overall health and a reduction in care gaps. Integrating BH services into existing frameworks (currently being examined by the State's CCBHC initiative and through the re-designed primary care delivery model) particularly in rural and frontier areas, expands access to essential care. This approach can be cost-effective by preventing complications related to untreated BH conditions, thereby reducing overall healthcare costs, utilization of emergency services, and reliance on state-run facilities. This recommendation is aligned with the State's efforts to redesign primary care and integrate BH.

Factors Supporting the Recommendation

- **Need for a holistic approach to care**: Integrated and collaborative models of care that address both physical and BH needs simultaneously recognize the interconnectedness of behavioral and physical well-being. A whole-person approach drives more comprehensive and effective treatment. Holistic treatment is particularly important to offer a "one-stop" primary care site for individuals traveling and using personal resources to attend appointments.
- **Improved coordination and communication**: Integrated care providers are better able to collaborate and share information within a comprehensive care management approach, reducing the risk of fragmented care and contra-indications in various treatment methods, including pharmaceutical interventions. The contributions of an integrated primary care provider to a comprehensive care team are essential to inform improved outcomes.
- **Increased access to BH services**: Integrating BH services into primary care settings, rural health clinics, hospitals, and other existing healthcare frameworks can significantly expand access, particularly in rural and frontier areas where BH providers may be scarce and local providers are known and better equipped to foster individual engagement.[19]

[19] Daryl Huggard, "Integrated Behavioral Health in a Clinical Primary Care Setting," September 10, 2020, https://www.mgma.com/articles/integrated-behavioral-health-in-a-clinical-primary-care-setting.

- **Cost-effectiveness**: Studies show that integrated care models can reduce overall healthcare costs by preventing complications and hospitalizations associated with untreated BH conditions.[20]

Quantitative Data that Informed the Recommendation

Primary care sites often serve as a key entry point for BH treatment, serving as an integral part of the overall care continuum. The Integrated Behavioral Health (IBH) model empowers primary care providers (PCPs) to conduct screenings for BH conditions, offer immediate specialized behavioral healthcare, and facilitate seamless referrals to BH providers. Data shown in Table 4 indicates that Region 1 has the highest number of IBH sites per 100,000 persons, potentially suggesting a higher reliance on these IBH providers due to a shortage of other types of BH providers in the region.

Table 4. IBH Sites by Region

Measures	Region 1	Region 2	Region 3	Region 4	Region 5	MT
Number of IBH Sites	16	12	12	19	36	95
IBH Sites / 100,000 persons	20.9	7.9	5.3	6.1	10.5	8.6
Population (2022)	76K	152K	227K	310K	342K	1.1M
BH Sites /10,000 Sq. Mi.	3.7	4.1	4.7	6.7	18.6	6.5

Table Note: The list of IBH providers reflects a point-in-time, is self-reported, and only includes IBH facilities currently receiving funding from the Montana Healthcare Foundation. IBH data provided by the Montana Healthcare Foundation. Cells shaded red represent the region(s) with the lowest number. Cells shaded green represent the region with the highest number.

Qualitative Data that Informed the Recommendation

Stakeholder feedback highlighted that current-state initiatives focused on integrating BH into primary care settings led to increased access across Montana and improved timeliness in identifying and responding to individuals with BH conditions. The need to expand these services into more primary care settings was strongly vocalized by stakeholders, particularly primary care and community MH providers within the Steering and Subcommittees. Stakeholders further voiced that the current shift towards primary care-centered models has the potential to hold immense opportunity to improve outcomes and address several key challenges through:

- **Deploying team-based approach**: IBH sites serve a critical role in Montana by providing care to the most geographically isolated population from key BH services (Region 1). Existing primary care models are inherently collaborative, fostering effective communication and coordination between physicians, nurses, and other healthcare professionals. This team-based approach readily incorporates BH specialists, creating a holistic care environment that addresses both physical and BH needs in rural and frontier regions where sites of care are limited or non-existent. The volume of services provided under this team-based approach will increase as Montana peer specialists, caregivers, and community health workers are incorporated into these models.
- **Prevention and education**: Integrating behavioral healthcare into primary care allows for proactive screenings, interventions, and preventative measures. Early identification

[20] Stephen Rocks et al., "Cost and Effects of Integrated Care: A Systematic Literature Review and Meta-Analysis," *The European Journal of Health Economics* 21, no. 8 (July 6, 2020): 1211–21, https://doi.org/10.1007/s10198-020-01217-5.

and management of issues like depression, anxiety, and substance misuse can significantly impact long-term health outcomes. Additionally, primary care settings provide ideal platforms for education and awareness about behavioral health, promoting self-care, and healthy lifestyle choices.

- **Addressing core issues**: Stakeholders called out that BH concerns often present as primary care issues. Montana has a network of evenly distributed IBH sites across the State, compared to other BH services, as shown in Figure 39. These sites can be expanded allowing individuals access to seamless primary care and BH treatment without compartmentalization. Taking this approach eliminates the risk of conflicting diagnoses or treatment plans, improving overall effectiveness. Furthermore, it acknowledges the interconnectedness of physical and behavioral health, leading to more comprehensive and person-centered care.
- **Streamlined coordination**: Throughout stakeholder meetings, participants repeatedly voiced the need for improved coordination and handoff processes. Integrated models address this directly by embedding BH specialists within the primary care team. This provider structure fosters real-time communication, decreased stigma, and shared individual information, reducing confusion and ensuring continuity of care across different care settings. With the addition of a Montana state-wide care coordination program, IBH sites can benefit through coordinated services outside of their practices, as well.

Anticipated Impact or the Recommendation

- **Improved physical and BH outcomes**: Early identification and management of BH conditions in primary care settings can lead to better outcomes for both physical and BH conditions,[21] addressing individuals' BH needs before those needs escalate to an acute level. In a comparable manner, addressing physical impairments helps to mitigate potential detrimental impact on an individual's BH.
- **Reduced stigma and increased comfort with accessing BH services**: Integration normalizes behavioral healthcare and makes it more readily available, potentially reducing stigma and encouraging individuals to seek help earlier.
- **Enhanced patient satisfaction**: Individuals benefit from a coordinated and person-centered approach to care, resulting in increased satisfaction and engagement with the healthcare system. Individuals benefit from a more routine face of primary care, which when coupled with consistent comprehensive care management – establishes a core team who can build relationships that foster engagement in care, continuity of care and, in the long-term, individual self-actualization.
- **Increased access to BH services**: Incorporating BH services in additional practices expands coverage to gap areas throughout the State by strategically leveraging the network of primary care provider sites, which is one of the most widely accessible sites of care based upon time and distance standards.
- **Reduced reliance on emergency services and state facilities**: Integrated behavioral care models can help connect individuals to BH services while BH conditions are still mild to moderate, helping prevent the need for higher intensity services, such as services provided by state-run facilities.

[21] Mary R. Talen and Aimee Burke Valeras, *Integrated Behavioral Health in Primary Care*, *Springer eBooks*, 2013, https://doi.org/10.1007/978-1-4614-6889-9.

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above.

- **Resistance to change**: Implementing new models requires buy-in from existing primary care providers, some of whom may be resistant to incorporating BH services into their practice, both from an operational and/or financial risk perspective.
- **Workforce shortages and training needs**: Effective implementation of integrated models requires access to qualified BH professionals, which can be a challenge in certain areas, such as Regions 1 and 2 in the eastern and northern parts of the State. Data analysis shows they have lower BH provider ratios relative to population. Appropriate training and incentives in underserved regions are crucial.
- **Funding and reimbursement challenges**: Current reimbursement structures may not adequately support integrated care models or reward high quality care outcomes, requiring policy changes and advocacy efforts.
- **Quality assurance and standardized implementation**: Ensuring consistent quality and fidelity to integrated care principles across different providers and settings is essential to maximize effectiveness on a statewide basis. These types of standards are difficult to monitor across multiple settings and requires a targeted approach that has sufficient technical oversight and administrative infrastructure.

Recommended Next Steps

- Identify high quality integrated practices across Montana and summarize outcomes and successes to promote to non-participating primary care offices.
- Develop and implement financial incentives for both PCPs and BH professionals to participate in integrated care models.
- Partner with BH and PCP organizations to facilitate workforce development and training programs for integrated care practice.
- Advocate for policy changes and reforms to promote adequate reimbursement and financing mechanisms for peer support specialists, caregivers, and community health workers employed at integrated care practices.
- Establish standardized protocols and quality assurance measures to promote consistent and high-quality implementation of integrated care delivery at participating practices.
- Develop evaluation and monitoring systems to track patient outcomes, cost-effectiveness, and overall program effectiveness to inform continuous improvement and gap identification.

Recommendation 1.5. Spread awareness of Medicaid reimbursement for mobile crisis services (recent State Plan Amendment) to encourage its expanded utilization.

As of July 1, 2023, Montana Medicaid has the authority to reimburse eligible providers for mobile crisis services. Historically, mobile crisis services operational costs have been state-

funded through the Crisis Diversion Grant Program, which did not provide sustainable funding for these services.[22]

As mobile crisis services are a newly covered Medicaid service, it is critical to continue to educate providers and other stakeholders about the availability of this new service to encourage appropriate utilization in the continuum of care. DPHHS held a public hearing in November 2023 that included notice of proposed amendments to the Administrative Rules and updates to the Behavioral Health and Developmental Disabilities Medicaid and Non-Medicaid Services Provider Manual regarding mobile crisis services.[23] DPHHS also posted proposed changes to the Provider Manual that incorporate the new mobile crisis response services policies. DPHHS published the adopted mobile crisis response services policies in April 2024, with those policies being retroactively effective July 1, 2023.

Factors Supporting the Recommendation

- **Increase availability of mobile crisis services**: Many BH providers are reluctant to offer mobile crisis services due to unreliable reimbursement. Raising awareness of expanded Medicaid coverage will incentivize provider participation and expand service availability.
- **Reduce reliance on law enforcement as the primary responder for BH crises**: Diverting appropriate crisis calls to specialized mobile crisis teams can decrease unnecessary law enforcement involvement and make sure individuals receive appropriate, trauma-informed care. To maximize the efficacy of acting on this recommendation, the study team notes that law enforcement entities should still be educated on their role versus the roles of mobile crisis teams to promote appropriate hand-offs, partnerships, and increased referral that drives crisis provider revenue via sustained volumes of appropriate referrals.
- **Improve early intervention and crisis stabilization with a lower cost method that is less traumatic**: Mobile crisis teams offer immediate support and de-escalation in the home or community, reducing the need for more intensive and costly interventions like hospitalization (including hospitalization at state-run facilities) and ED visits and/or jail stays.
- **Mobile Crisis Response:** Mobile crisis services play a vital role in the comprehensive crisis care continuum and individuals receiving care from these specialized services express greater satisfaction compared to traditional emergency response methods (e.g., 911 and EDs).
- **Crisis Receiving and Stabilization:** Maintaining access to Crisis Receiving and Stabilization in communities with existing programs is crucial, as they serve over half of Montana's population, including Crisis Receiving locations in Missoula and Yellowstone, along with Crisis Stabilization units in Missoula and Ravalli.[24]

[22] "Recommendation for Consideration: Grants to support Mobile Crisis Response and Crisis Receiving and Stabilization services." Behavioral Health System for Future Generations Commission, 2023. https://dphhs.mt.gov/assets/FutureGenerations/BHSFGRec-CrisisServices.pdf.

[23] "Pertaining to Chemical Dependency Programs and Medicaid Mental Health Services, MAR Notice No. 37-1039," by Department of Public Health and Human Services, Department of Public Health and Human Services of the State of Montana, November 9, 2023, https://dphhs.mt.gov/assets/rules/37-1039pro-arm.pdf.

[24] "Recommendation for Consideration: Grants to support Mobile Crisis Response and Crisis Receiving and Stabilization services."

Qualitative Data that Informed the Recommendation:

- Stakeholders reported significant, ongoing efforts by groups including Montana's Behavioral Health and Developmental Disabilities Division, Montana Healthcare Foundation, Montana Public Health Institute, and the Behavioral Health Alliance of Montana to create the Crisis Now Collaborative and implement the *Crisis Now Model* in Montana. The recent Medicaid State Plan Amendment now enables Medicaid reimbursement for mobile crisis services. As of mid-August 2023, eight communities indicated having active mobile crisis teams. This recent State Plan Amendment is important as it:
    - Removes a major financial barrier to access. Many individuals experiencing BH crises struggle with affordability. By raising awareness that these services are now Medicaid-reimbursable, both provider provision and client use of services can be expanded. Increased awareness will lead to increased adoption as community members feel more secure in their ability to rely on a new service model. Increased utilization should lead to positive outcomes for those in need of crisis care.
    - Raises awareness that can empower communities. Equipping stakeholders and providers, including first responders, community organizations, and even individuals themselves, with knowledge of the State Plan Amendment can allow for appropriate access and expansion of mobile crisis services. This fosters a more proactive and comprehensive approach to BH emergencies.
    - Promotes awareness of new Medicaid reimbursement for mobile crisis services and can aid in creating a sustainable system that prioritizes accessibility, empowers providers, and breaks down barriers to promote comprehensive and timely behavioral healthcare for all.

Anticipated Impact of the Recommendation

- **Improved BH outcomes**: Timely access to mobile crisis services can lead to better symptom management, reduced crisis episodes, increased engagement in long-term treatment, and reduced costs associated with IP hospitalization at state-run or private facilities.[25]
- **Reduced community disruption and stigma**: De-escalating crises in the community can minimize disruption and fear and increase understanding and empathy for individuals experiencing BH challenges.
- **Enhanced public safety**: Diverting BH crises from law enforcement can free up officers for other duties and potentially reduce the risk of unnecessary escalation when mobile crisis teams respond versus a uniformed official and minimize the need for forceful responses.
- **Strengthened BH system**: Expanding mobile crisis services can create a more comprehensive and integrated BH system, improving access to care and overall health outcomes.[26]

[25] "National Guidelines for Behavioral Health Crisis Care," National Association of State Mental Health Program Directors (NASMHPD), 2020, https://www.nasmhpd.org/content/national-guidelines-behavioral-health-crisis-care.

[26] "Assessing the Impact of Mobile Crisis Teams: A Review of Research." University of Cincinnati, 2020. https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Mobile%20Crisis%20Team%20Evaluations.pdf.

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above.

- **Limited awareness and outreach**: Healthcare providers, individuals in need, and community members currently lack knowledge about the availability and benefits of mobile crisis services that were newly covered by Medicaid as of July 1, 2023. Awareness needs to be targeted and partnerships formed that enable grassroots awareness among parties most likely to refer individuals in crisis (e.g., law enforcement, medical providers, community champions, grocers, and retailers). Montana's Behavioral Health and Developmental Disabilities Division participates in the Crisis Coordinator Network monthly calls with counties, which have been an existing platform to provide crisis-related updates to counties. In addition, the Montana Public Health Institute has contracted staff to help educate local crisis coordinators and Loveland Consulting provides Sequential Intercept Model mapping with communities.
- **Workforce capacity and training**: Ensuring sufficient qualified clinicians and crisis responders staffed at mobile crisis teams requires investment in workforce development and training.
- **Service availability and geographic disparities**: Rural and frontier areas and underserved communities may face challenges in accessing mobile crisis services due to geographic limitations or insufficient resources. Making services available in remote communities with limited resources may require targeted investments that enable service mobilization.
- **Potential for misutilization**: Improper use of mobile crisis services for non-urgent situations could increase costs and strain resources, which would require educational campaigns that equip community members with an understanding of when 911 is appropriate vs 988, the Suicide Prevention and Mental Health Crisis Lifeline.
- **Sustainable Funding**: Potential insufficient Medicaid funding poses a threat to sustaining the existing mobilization fleet. There is a likelihood of requiring supplemental funding to maintain or expand these services. A one-time funding opportunity exists through the BHSFG grant aims to sustain and stabilize existing Mobile Crisis Response and new Crisis Receiving and Stabilization providers.[27,28]

Recommended Next Steps

- Develop targeted awareness campaigns for healthcare providers, individuals, and communities to provide education about newly covered Medicaid mobile crisis services.
- Further partner with BH providers to promote and incentivize the adoption of mobile crisis programs.
- Identify appropriate responders and care protocol for better integration of incoming 911 and 988 calls based on location and acuity.
- Invest in workforce development programs to train and recruit qualified mobile crisis team members, particularly in rural and frontier areas.

[27] "BHSFG Recommendation for Consideration: Crisis Services."

[28] "Governor Gianforte Invests $8 Million to Improve Behavioral Health Crisis Response in Montana."

- Conduct data analysis and monitoring to track service utilization, identify geographic disparities, and inform resource allocation and service expansion.
- Implement clear referral guidelines and protocols to foster appropriate utilization of mobile crisis services and prevent misuse.
- Partner with community organizations and law enforcement to build referral networks and promote collaborative responses to BH crises.

2. Access Priorities

The study team recommends that the State offer additional acute, sub-acute, and OP facilities dispersed across Montana in BH access shortage areas. Currently, MSH is at capacity and stakeholders indicate that individuals travel long distances to receive care, particularly higher acuity care. To reduce patient volumes at the state facilities and ensure that Medicaid enrollees are being served in the most clinically appropriate settings, the study team recommends introducing settings that would provide care closer to individuals' homes at an appropriate acuity level. Additional settings would benefit all those living in the area.

Discussions with Steering and Subcommittee members and an analytical study of Montana claims data identified significant gaps exist in IP, sub-acute care, and OP care in Regions 1 and 2. Figure 11 illustrates gaps in care in Montana. Gaps are crisis and stabilization care, residential and group homes, and Partial Hospitalization Programs (PHP) / Intensive Outpatient Programs (IOP). A larger version of these figures is available in Appendix B.

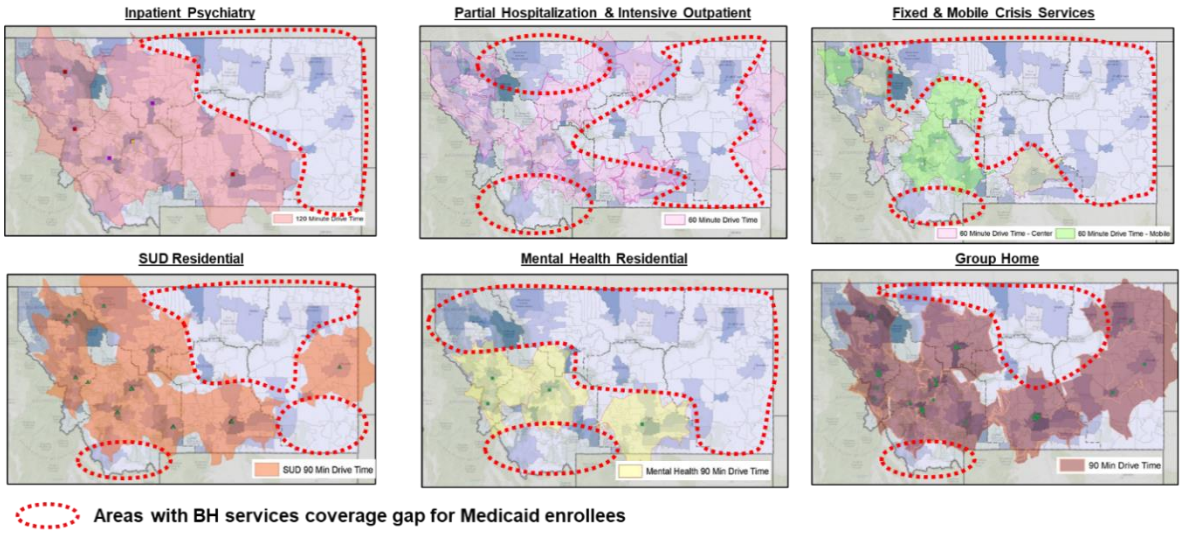


Figure 11. Overview of Key Behavioral Healthcare Settings Gaps in Montana[29]

Figure Note: Figure 11 shows areas where behavioral healthcare coverage is lacking for Medicaid population for various behavioral healthcare settings. Behavioral healthcare setting definitions can be found in Table 14.[30]

[29] Medicaid claims, DPHHS, SAMHSA, Medicare Compare and other public sources as of November 202320232023, Clarivate.

[30] "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit," *Substance Abuse and Mental Health Services Administration (SAMHSA)*, 2020, https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

The projected space needs (e.g., bed, chairs, mobile units) are outlined by gap area in Figure 12. National studies indicate that by offering accessible services to individuals earlier in their illness, progression of symptoms is mitigated and the need for IP care lessened.

The team recommends investments in acute, sub-acute, and OP services that are strategically placed to address measurable gaps in care access, reduce reliance on care provided at MSH, and focus on prevention to prevent the escalation of acuity. This approach allows for treatment to be provided in an appropriate setting that prevents the need for institutionalization by better matching individual acuity to setting acuity. A strategy focused on broadening sub-acute and OP access also encourages the involvement of family and other informal supports in the recovery and healing journey.

The study team recommends that existing underutilized facilities be considered as potential sites for the co-location of BH services. Sites recommended for consideration include acute care and critical access hospitals or decommissioned or partially vacant nursing homes. Potential partners should be identified through Montana's procurement process, outlining services needed by region and partnership requirements. If responses to a procurement do not lead to identifying a willing and able partner for co-location, then a new-build approach may be necessary to provide coverage in identified areas.

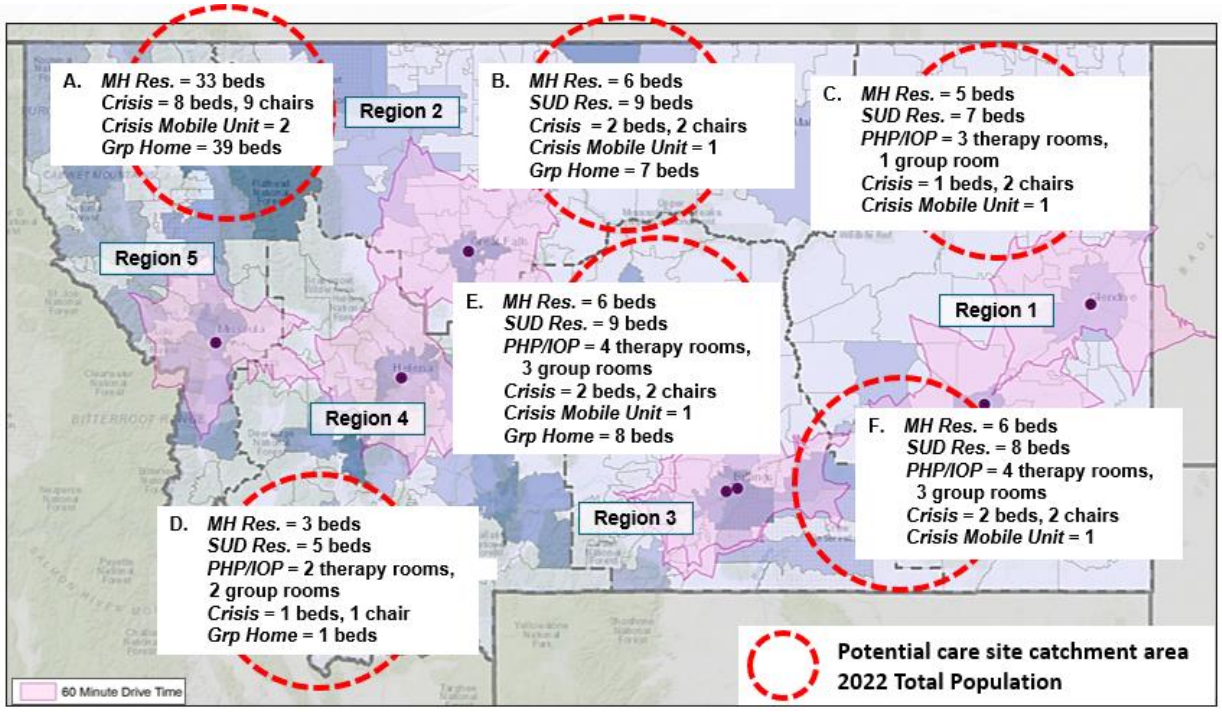


Figure 12. Proposed Sub-Acute Care Sites

Figure Note: Key Planning Unit (KPU) calculations are based on data from SAMHSA's N-MHSS (2018) and N-SSAT (2019) surveys and Crisis Resource Need Calculator (crisisnow.com). Other resources include Claritas and Clarivate (2022 Medicaid Enrollees). The calculation of behavioral healthcare site needs is current as of November 2023. Crisis "chairs" refers to 23-hour observation chairs or recliners used instead of beds in a crisis center to address the needs of a BH individual experiencing a crisis.

At this time, no locations or potential partners have been identified, but rather facility model options have been reviewed on the premise of co-location of services in one facility, on a

campus, or within several miles of one another. Prioritization of where these facilities and services will be located is dependent on a range of factors outlined below:

- Lack of any existing services in the area based upon measurable drive-time to nearest facility providing these services,
- Population demand-based volume projections,
- Projected magnitude of cost,
- Feasibility of staffing co-located care settings that are existing or newly built.

Access recommendations with criteria weighting assignments and resulting priority scores are shown in Figure 13.

Recommendations	Broad BH Ecosystem Impact	Subcommittee Priority	Investment Commitment	BHSFG Commission Priority	Implementation Complexity	Level of Effort	Initial Score
2.1 Expand community-based crisis receiving and stabilization centers.	High	High	$$$	High	Moderate	High	24
2.2 Enhance access to Comprehensive Behavioral Healthcare Campuses, especially in the east, to improve transitions between acute, sub-acute, and OP care.	High	Moderate	$$$$	High	Moderate	Moderate	22
2.3 Increase capacity of in-state residential treatment and group homes for the pediatric population to reduce out-of-state care.	Moderate	High	$$$	Moderate	Moderate	High	18

Figure 13. Access Recommendations Scorecard

Recommendation 2.1. Expand community-based crisis receiving and stabilization centers.

Montana has already moved towards addressing BH challenges by earmarking up to $7.5 million in near-term initiative funds for supports for mobile crisis response and crisis receiving and stabilization services. The near-term initiative aims to divert individuals away from local EDs, jails, and state-run healthcare facilities. Further expansion of community-based crisis receiving and stabilization centers can bolster resources for providers further diminishing the use of ED, jails, and state-run facilities.

The study team recommends that the State issue a procurement to invite providers interested in providing crisis receiving and stabilization services in areas of the State that lack sufficient access to such services (e.g., Regions 1, 2, and 3). The procurement can fund start-up costs for providers to cover costs such as capital, renovation, equipment, and technology costs. Start-up costs may be funded by a combination of sources such as BHSFG funding, USDA rural development grants or loans, and HRSA grants. The State may also require a provider matching contribution. As part of the procurement process, providers can be required to outline projected volumes, revenue, and staffing models for crisis receiving and stabilization services to ensure that the centers are financially viable once the start-up phase is complete. Examples of payors include Medicaid, Medicare, private health insurance, and private pay. The State can also invest in workforce development and training programs to build a qualified pool of professionals to staff the centers, including peer support specialists.

If the State is awarded the CCBHC Demonstration Grant, CCBHCs will be responsible for community-based crisis receiving services and have coverage across most regions. However, crisis stabilization services will still be needed, which is not a requirement of CCBHCs. The study team proposes that additional provider locations offering crisis stabilization services may be part of Comprehensive Behavioral Healthcare Campuses, as described in Recommendation 2.2.

Factors Supporting the Recommendation

- **Reduce reliance on EDs for BH crises**: Statewide EDs are not tailored to effectively handle BH crises, often leading to lengthy stays, inappropriate prescribing of medication, increased distress for individuals, and potential safety risks to staff and individuals.
- **Provide specialized care in a safe and supportive environment**: Crisis receiving and stabilization centers for individuals that focus on de-escalation, stabilization, and connection to appropriate BH services, offer a more therapeutic and person-centered approach.
- **Improve access to care for underserved populations**: Many individuals experiencing BH crises lack access to traditional OP services. Centers in convenient locations can address this gap and reduce stigma associated with seeking help. Additionally, increased connectivity of Montana 988 to local community-based centers can help improve care continuity.
- **Decrease overall healthcare costs**: Studies show that diverting BH crises from EDs to specialized crisis centers can result in significant cost savings.[31]

[31] "National Guidelines for Behavioral Health Crisis Care."

- **Crisis stabilization can be provided in a variety of settings**: Crisis stabilization can be provided in the ED, adjacent to an ED, on a hospital campus, or in an OP emergency facility, which provides options for facility solutions across the State.

Quantitative Data that Informed the Recommendation

- Montana has a measurable gap in its behavioral healthcare system that impedes timely crisis intervention, particularly a lack of accessible crisis stabilization sites in Region 1. While some crisis care exists in more populated western areas, these specialized settings are scarce across much of the State. An unequal distribution shown in Figure 14 leaves residents in Regions 1, 2, and 3, along with many others scattered throughout Montana, struggling to find immediate help during BH crises. A lack of accessible care can have grave consequences including delaying treatment, worsening outcomes, and increasing the strain on emergency services.

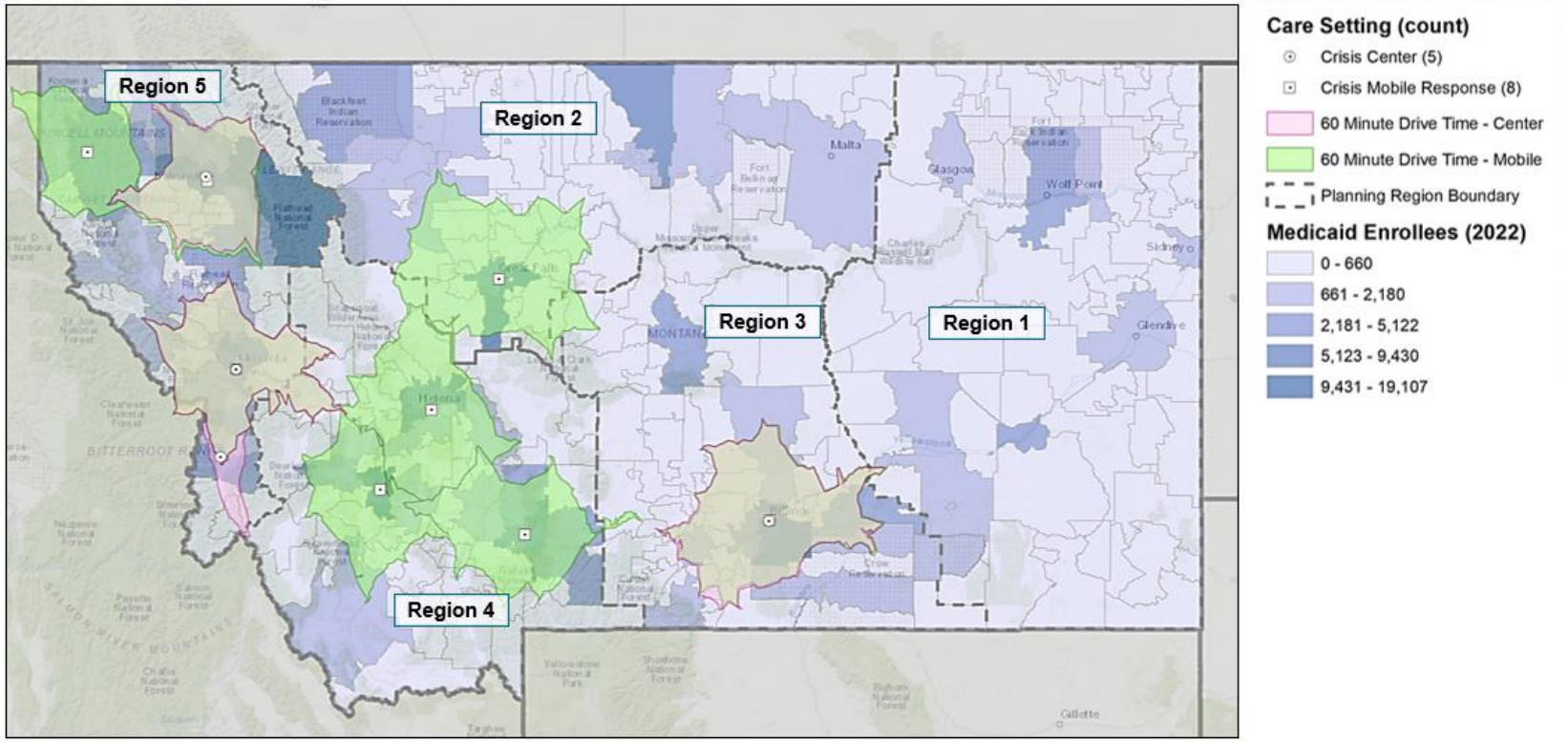


Figure 14. Accessibility of BH Crisis Care by Region

Figure Note: Tan colored drive-time zones show areas where crisis center and crisis mobile response catchment areas overlap, resulting in the light tan color observed. The calculation of behavioral healthcare site needs is current as of November 2023. In December 2023, the Great Falls crisis center site closed; only seven sites remain.

Anticipated Impact of the Recommendation

- **Improved clinical outcomes**: Early intervention and specialized care can lead to better symptom management, reduced crisis episodes, and increased engagement in long-term treatment.
- **Reduced inappropriate use of law enforcement**: Fewer inappropriate responses to BH crises by law enforcement can strengthen community-law enforcement relations and improve safety for all.
- **Reduced reliance on emergency services and state facilities**: Crisis receiving and stabilization centers can result in reduced utilization of EDs, ED boarding, IP hospitalizations (including hospitalizations at state-run facilities), and arrests.[32]

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above.

- **Funding and staffing challenges**: Implementing and maintaining a network of centers requires sustained funding and qualified personnel, which can be difficult in rural and frontier areas.
- **Capacity and access limitations**: Centers may become overwhelmed, creating wait times and potential access barriers for individuals in need.
- **Quality of care concerns**: Ensuring all centers offer culturally relevant, trauma-informed care with strong linkages to follow-up services can reduce fragmentation of care.
- **Opposition from existing stakeholders**: Traditional providers and law enforcement may resist changes to the current system, requiring public education and outreach.

Recommended Next Steps

- Use Montana's procurement process to request a mix of public and private resources to identify existing providers or new market entrants offering crisis receiving and stabilization services. Potential sources of funding can include BHSFG funding, USDA rural development grants or loans, and HRSA grants. The State may also require a provider matching contribution.
- Invest in workforce development and training programs to build a qualified pool of professionals to staff the centers including peer support specialists.
- Establish clear clinical guidelines and quality standards for all centers to provide consistent, high-quality care.
- Develop strong partnerships with existing BH providers, law enforcement, 988, and community organizations to facilitate referrals and seamless transitions of care.
- Implement data collection and monitoring systems to track outcomes and inform continuous improvement efforts.

[32] Margie Balfour, "An Imperfect Guide to Crisis Stabilization Unites: Matching the Right Level of Care to Individual Needs," Psychiatric Times, May 5, 2023, https://www.psychiatrictimes.com/view/an-imperfect-guide-to-crisis-stabilization-units-matching-the-right-level-of-care-to-individual-needs

- Develop public awareness campaigns to build community support and reduce stigma surrounding requesting help and accessing crisis stabilization centers.

Recommendation 2.2. Enhance access to Comprehensive Behavioral Healthcare Campuses, especially in the east, to improve transitions between acute, sub-acute, and outpatient (OP) care.

Comprehensive Behavioral Healthcare Campuses offer a solution to the challenge of care gaps and geographic dispersion of what care is available, presenting a unique opportunity to improve an individual's journey and improve quality of care by housing multiple healthcare service lines into a single, or closely located suite of care sites that are easily accessible by individuals requiring comprehensive services. Additionally, Comprehensive Behavioral Healthcare Campuses can bring specialized care closer to home, alleviating long travel times to multiple clinics. For the purposes of this recommendation, a Comprehensive Behavioral Healthcare Campus is a care location in a community setting that provides a range of acute, sub-acute, and OP care. A Comprehensive Behavioral Healthcare Campus may be operated by one entity, or multiple entities that partner to provide services across the BH continuum. For example, the study team envisions that one scenario for a Comprehensive Behavioral Healthcare Campus could include a CCBHC that provides OP BH services partnered with another provider entity or entities that deliver IP and residential BH services. Figure 15 displays potential partners that may be part of a Comprehensive Behavioral Healthcare Campus, depending on identified BH service gaps.

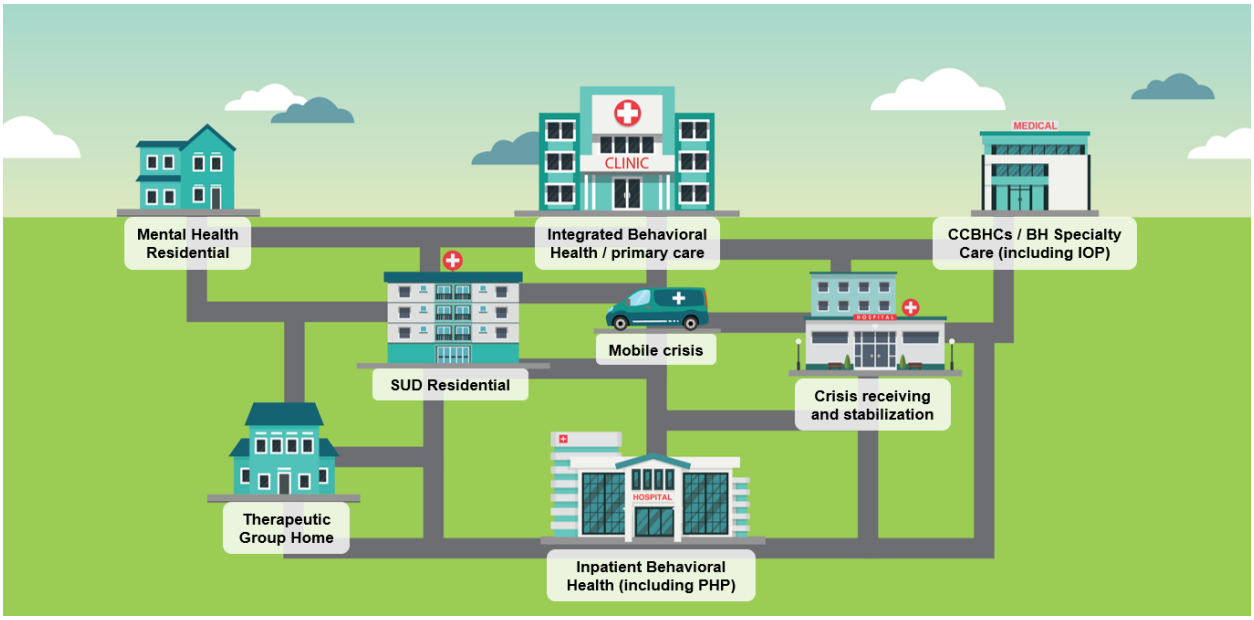


Figure 15. Potential Partners in a Comprehensive Behavioral Healthcare Campus

Under this recommendation, the State can issue a procurement to invite a provider or partnership of providers to serve as a Comprehensive Behavioral Healthcare Campus in each region. The procurement can fund start-up costs for providers to cover costs such as capital, renovation, equipment, and technology costs. Start-up costs may be funded through a combination of sources such as BHSFG funding, USDA rural development grants or loans, and HRSA grants. The State may also require a provider matching contribution. As part of the procurement process, the State can require providers to outline projected volumes, revenue, and staffing models for BH services to ensure that the Comprehensive Behavioral Healthcare

Campus is financially viable once the start-up phase is complete. Examples of payors that will contribute to sustainable funding include Medicaid, Medicare, private health insurance, and private pay.

Factors Supporting the Recommendation

- **Reduced admissions to MSH**: Expanding access to Comprehensive Behavioral Healthcare Campuses, particularly in underserved areas like eastern Montana, strengthens the State's continuum of care. A Comprehensive Behavioral Healthcare Campus provides more appropriate treatment options at various points along an individual's journey, potentially diverting individuals from requiring hospitalization at the state hospital. By offering a wider range of services in community settings (acute, sub-acute, and OP), individuals can receive targeted interventions closer to home, potentially preventing crises that might necessitate admission to the state hospital. This approach promotes a more comprehensive and cost-effective care delivery system.
- **Maximize preventive and routine care to avoid preventable escalation:** Providing care close to home such as counseling, medication management, group therapy, and crisis stabilization lessens the need for more acute IP services and provides a "medical home" for BH needs.
- **Improved care continuity:** A Comprehensive Behavioral Healthcare Campus can provide acute, sub-acute (e.g., PHPs) and OP services in one location or near one another to streamline transitions. This is especially crucial for individuals in eastern Montana who may face transportation barriers in accessing different care sites.
- **Consolidated services regionally**: Offering MH or SUD residential housing, acute services, IOP/PHP, crisis intervention, individual and group therapy, and support in one facility or several close by allows individuals to become comfortable with treatment facilities and providers working in those facilities for their varying levels of care needs.
- **Reduced gaps and readmissions:** Seamless transitions prevent potential treatment gaps and rehospitalizations, leading to better long-term recovery outcomes and reduced healthcare costs.
- **Enhanced coordination and communication:** Comprehensive Behavioral Healthcare Campuses facilitate collaboration between sub-acute and OP teams, enabling more effective communication and tailored treatment plans addressing individual needs.
- **Increased access to specialized services:** Integrating sub-acute and OP services in eastern Montana can make specialized care more readily available to residents in the rural and frontier areas of the State.

Quantitative Data that Informed the Recommendation

Figure 16 shows that Montana regions consistently lack access to the full spectrum of BH services (especially in eastern Montana). Investing in a multitude of new, independent care sites would not be a sustainable solution based on cost implications. Dispersed sites dilute the economies of scale in cost and labor allocation that are necessary for long-term sustainability. A more cost-effective approach is to offer multiple BH services within a campus, with services in nearby proximity to each other. A Comprehensive Behavioral Healthcare Campus strategy focuses on areas with low population density and limited BH workforce, making services readily available without excessive duplication of efforts.

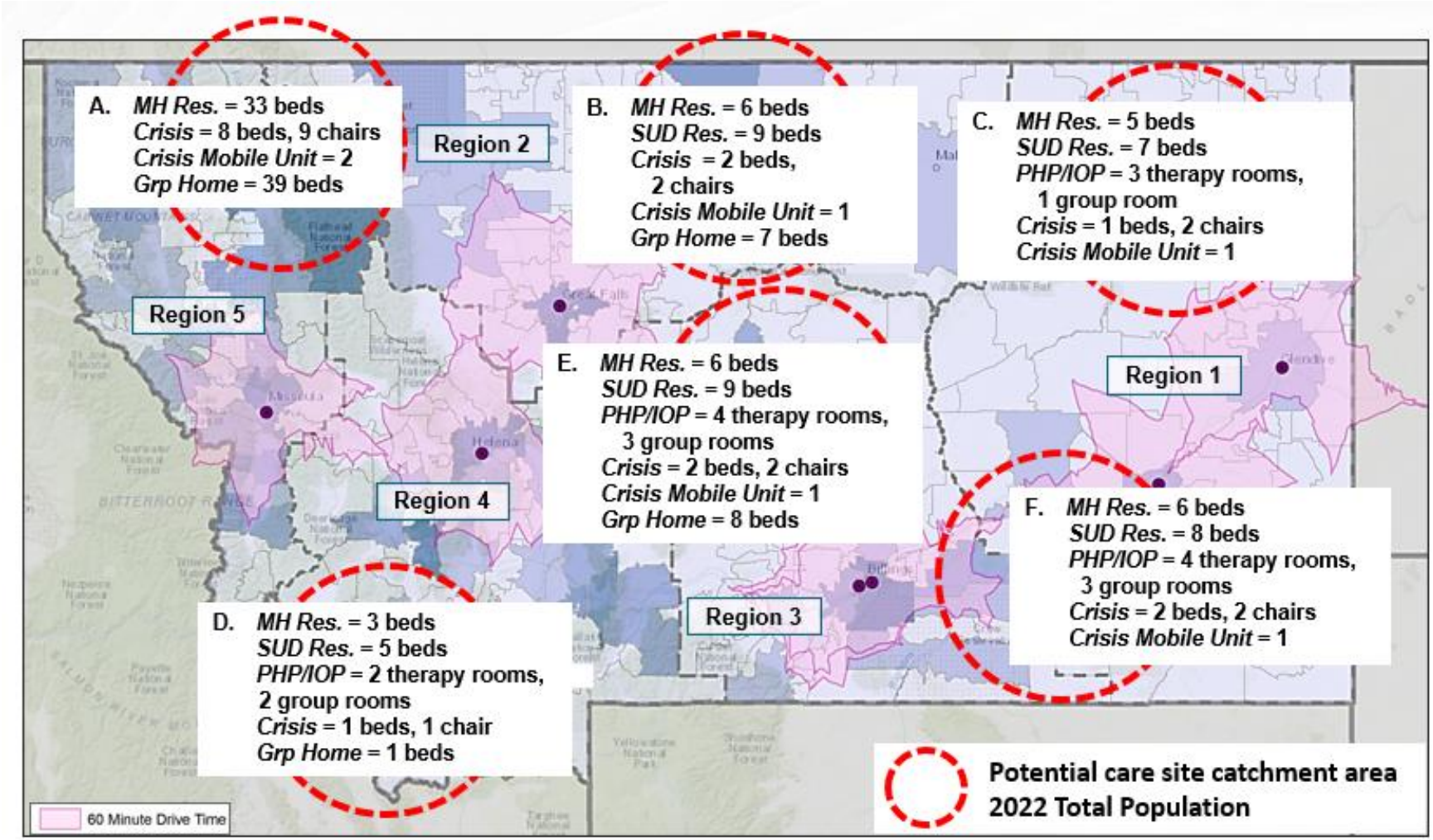


Figure 16. Proposed Comprehensive Behavioral Healthcare Campuses

Anticipated Impact of the Recommendation

- **Improved client outcomes:** Treatment continuity and coordination can lead to improved symptom management, increased adherence to medication regimens, and overall enhanced individual well-being.[33]
- **Reduced healthcare costs:** Avoiding readmissions and unnecessary sub-acute care utilization through smoother transitions can significantly reduce healthcare costs for both individuals and the State.
- **Strengthened BH infrastructure in eastern Montana:** Establishing or expanding Comprehensive Behavioral Healthcare Campuses in eastern Montana can strengthen the overall BH system by addressing existing access disparities and providing comprehensive care closer to home.
- **Maximized workforce productivity:** Consolidating services in one facility, or in proximity, can allow for shared staffing / resources in areas where utilization needs are lower or lacking and human resources are limited.
- **Improved satisfaction in care:** Enhanced coordination and personalized care within one location can lead to increased individual satisfaction with the overall treatment experience.

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above. The State can issue a procurement in which hospitals, RTFs, or Crisis Stabilization centers submit a response to offer comprehensive services in one facility, on the same campus, or through multiple nearby facilities. These Comprehensive Behavioral Healthcare Campuses can improve access for individuals with BH conditions and maximize staff efficiency, while reducing IP care needs at MSH over time.

- **Partnership commitment:** Consistent and continued operations of acute, sub-acute, and OP services relies on the ability of partners to manage their operations effectively, efficiently, and maintain a high-quality care delivery. If any of these standards are not upheld, a gap in care could negatively impact individuals seeking and/or receiving care.
- **Funding and resource constraints:** Establishing and maintaining Comprehensive Behavioral Healthcare Campuses requires dedicated funding for infrastructure renovation or construction, staff training, and ongoing operational costs. Securing and sustaining funding requires careful planning and collaboration.
- **Workforce availability and expertise:** The areas that would be most in need of co-located services are rural and frontier areas. Recruitment, retention, and recertification strategies of workforce are more challenging in rural and frontier areas.
- **Integration and technology challenges:** Smooth integration of sub-acute and OP services requires robust IT systems, shared electronic health records, and standardized treatment protocols for consistency of care.

[33] Sarah Bajorek and Vanessa McElroy, “Discharge Planning and Transitions of Care,” Patient Safety Network, September 7, 2019, https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care.

- **Cultural competency and accessibility:** Comprehensive Behavioral Healthcare Campuses must be culturally relevant and accessible to diverse populations across Montana. Addressing language, cultural barriers, and transportation needs is crucial.
- **Institution for mental disease (IMD) exclusion:** Federal law prohibits IMDs from being eligible for Medicaid payment for services provided to individuals aged 21-64. An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes SUD.[34] It is important to note that any facilities created with more than 16 beds qualify as an IMD and therefore are not eligible for Medicaid reimbursement, unless the State receives a mental health IMD 1115 waiver.[35] On July 1, 2022, Montana received CMS approval for the SUD IMD component of the HEART 1115 Waiver, allowing the State to receive Medicaid reimbursement for SUD IMD services. In addition, Montana has a pending amendment to the HEART 1115 Waiver to add stays by children and youth with serious emotional disturbance at IMDs that are also Qualified Residential Treatment Centers.[36]

Recommended Next Steps

- **Develop a collaborative implementation plan:** Engage stakeholders (BH professionals, community organizations, those with lived experience, and funding agencies) in planning and designing the care sites, ensuring cultural competency and community buy-in.
- **Identify partners:** Issue a procurement to solicit potential providers to share space and resources to strengthen the behavioral healthcare delivery system, while minimizing implementation costs.
- **Secure funding:** Explore diverse funding sources, including public-private partnerships, grants, and state allocations, to promote long-term financial sustainability.
- **Invest in workforce development:** Implement training programs and recruitment strategies to attract and retain qualified professionals for IP, sub-acute, and OP services, considering geographic location and cultural sensitivity.
- **Develop standardized protocols and technology infrastructure:** Establish clear protocols for transitions between sub-acute and OP care within Comprehensive Behavioral Healthcare Campuses and invest in robust technology platforms for seamless communication and shared electronic health records.

Recommendation 2.3. Increase capacity of in-state residential treatment and group homes for the pediatric population to reduce out-of-state care.

Expanding in-state pediatric facilities for residential treatment and group homes in Montana can reduce costly out-of-state placements for the pediatric population and keep children closer to their home communities during residential treatment. This not only improves access to family and natural supports but also allows for care within familiar cultural and community contexts. Through survey and key stakeholder interviews, it is recognized that smaller residential and

[34] "Payment for services in institutions for mental diseases," Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/.

[35] For individuals under age 21, only services delivered in a psychiatric residential treatment facility, a psychiatric hospital, or a psychiatric unit of a general hospital are exempt from the IMD exclusion.

[36] "Medicaid Section 1115 Demonstration Amendment Request: Healing and Ending Addiction through Recovery and Treatment (HEART) Demonstration," DPHHS, November 29, 2023, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mt-heart-demonstration-pa.pdf.

group settings are essential in increasing capacity of Montana's residential system for the pediatric population with a Serious Emotional Disturbance. A unique reimbursement rate for four-bed group homes can incentivize providers to provide residential care to the pediatric population with complex needs that cannot be successfully served in eight-bed Therapeutic Group Homes.

The State has implemented recent improvements that will support Montana's Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes to serve more patients in-state. These changes include updates to Medicaid reimbursement for residential care, including implementing parity in rates between in-state and out-of-state providers. Additionally, the State has implemented a provider work group to clinically staff pediatric cases with unmet complex needs at risk of being referred to an out-of-state residential setting. This clinical staffing will focus on identifying specific services and interventions that may be implemented within a Montana residential setting.

The study team recommends the following actions to increase capacity of in-state residential treatment and group homes for the pediatric population:

- Explore acuity-based reimbursement models as a method to incentivize providers to care for the pediatric population with diagnoses or behaviors that have been identified as factors leading to out-of-state residential placements including aggression, maladaptive sexual behaviors, and co-occurring MH diagnoses and autism among others,
- Offer training to providers in caring for the pediatric population with complex conditions and co-occurring BH and I/DD diagnoses,
- Identify need for additional procurement for expanding capacity for residential treatment and group homes. The procurement can fund start-up costs for providers to cover costs such as capital, renovation, equipment, and technology costs. Start-up costs may be funded by a combination of sources such as BHSFG funding, USDA rural development grants or loans, and HRSA grants. The State may also require a provider matching contribution.

The study team proposes that expanded capacity through residential treatment and group homes may be part of Comprehensive Behavioral Healthcare Campuses, as described in Recommendation 2.2.

Factors Supporting the Recommendation

- **Reduced out-of-state placements:** Montana currently sends many individuals from the pediatric population requiring residential treatment and group homes out-of-state due to limited in-state options. Expanding in-state capacity can dramatically reduce these costly and disruptive placements.
- **Improved family support and engagement:** Keeping the pediatric population closer to home allows for easier family contact and involvement in treatment, fostering stronger support systems and facilitating smoother transitions back into their communities.
- **Cultural and community connections:** Access to in-state facilities allows the pediatric population to receive care within their familiar cultural and community contexts.
- **Targeted, specialized care:** The pediatric population's needs can be more complex than adults, requiring smaller residential and group settings and more one-on-one

clinical attention, necessitating four-bed group and residential homes that meet clinical or population criteria.

Quantitative Data that Informed the Recommendation

A closer look at Medicaid claims reveals there is a need for at least 15 IP pediatric beds and 55 pediatric residential beds based on the volume of the pediatric population receiving care at out-of-state facilities (when compared to receiving care in-state). The trend of out-of-state placement not only disrupts crucial support networks and family connections but also highlights potential gaps in local service provision. Figure 17 shows the bed demand for IP and residential services for pediatric Medicaid enrollees who received services from out-of-state facilities by region. For example, pediatric Medicaid enrollees in Region 5 received residential BH services at centers outside the state equivalent to days of care that could fill 17 beds. This means that if Montana were to create a facility in the region to meet the demand for residential pediatric services in 2022, the facility would require 17 beds equipped with the resources, workforce, and expertise required to meet the needs of pediatrics of that region who received care out-of-state.

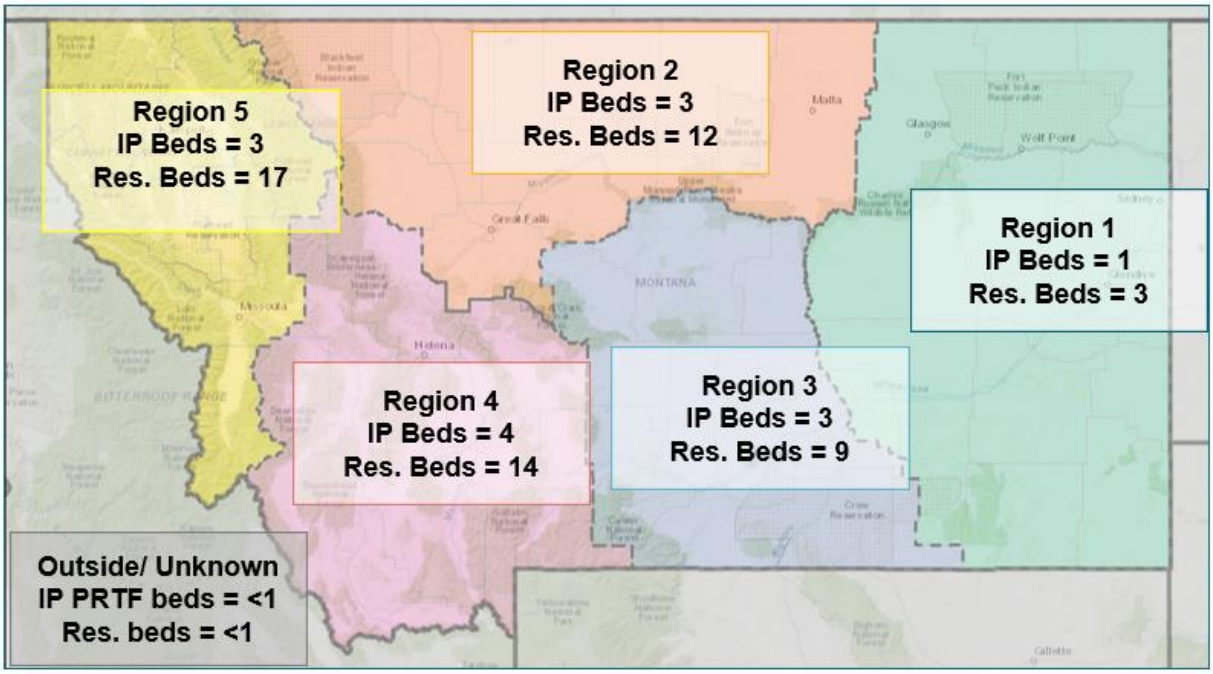


Figure 17. Pediatric Medicaid Enrollees at Out-of-State Facilities – Current Bed Demand Based on Region of Origin[37]

Figure Note: Current space demand assumes 85% occupancy rate to allow for seasonal variation in demand for beds. Residential beds include SUD residential, MH residential, group homes and other congregate settings involving an overnight stay (excluding ED visits). Pediatrics include ages 0 to 17.

Qualitative Data that Informed the Recommendation

After speaking with stakeholders, it became evident there is a critical shortage of in-state residential treatment and group home beds for the pediatric population. Stakeholders indicated that a main barrier to in-state pediatric population placement is based on providers' capacity to work with high complexity pediatric populations. Beds may exist, but access is restricted due to

[37] Medicaid claims data (inpatient, outpatient, and professional billing) for enrollees with a BH or I/DD diagnosis in CY 2022.

narrow criteria focusing on presenting behaviors, excluding the pediatric population with various needs, including those with:

- **Autism**: In-state options for the pediatric population with autism are scarce, pushing them out-of-state.
- **Dual diagnosis with Autism**: Pediatric population with co-occurring autism struggle to find placement.
- **Problematic sexual behaviors**: More bed availability is not necessarily needed, but loosening exclusionary criteria is crucial.
- **Medical and social complexities**: PRTFs in Montana lack the capacity to handle medical conditions (e.g., diabetes) and social complexities (e.g., aggression) requiring out-of-state placements.
- **Substance Use Disorder**: There are no in-state residential settings for the pediatric population to address a primary SUD.

Anticipated Impact of the Recommendation

- **Improved treatment outcomes:** Keeping the State's pediatric population closer to home potentially enhances their well-being by reducing separation anxiety and fostering a greater sense of security and stability.
- **Reduced disruption to social development:** Receiving care closer to home can allow the pediatric population to maintain connections with friends and community networks, contributing to their overall development and healing.
- **Strengthened local BH infrastructure:** Expanding pediatric in-state facilities strengthens the overall BH infrastructure in Montana, contributing to a more comprehensive and accessible system for all residents.
- **Added care for individuals in rural and frontier areas and individuals with complex conditions:** Updating licensure and reimbursement to allow for smaller residential and group pediatric sites (four-bed facilities) to treat patients with complex conditions and pediatric populations residing in regions will allow for the provision of targeted, specialized care.

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above.

- **Funding and resource constraints:** Expanding or identifying pediatric treatment facilities requires significant investments in infrastructure improvements or construction, staffing, and ongoing operational costs. Finding stable funding sources and ensuring efficient resource allocation is critical.
- **Quality of care and workforce challenges:** Ensuring high-quality care in pediatric residential and group homes requires competent staff and specialized training. Attracting and retaining qualified professionals, particularly in rural and frontier areas, can be challenging.
- **Accessibility and location considerations:** Facilities should be strategically located to promote equitable access for the pediatric population across Montana, particularly in

underserved rural and frontier areas. Balancing geographic spread with resource sustainability requires careful planning.

Recommended Next Steps

- **Develop a strategic plan:** Based on the needs assessment, create a comprehensive plan outlining the type and capacity of facilities, location considerations, funding strategies, and workforce development initiatives.
- **Engage stakeholders and secure funding:** Collaborate with community stakeholders, BH professionals, families, and funding agencies to foster community buy-in, secure long-term funding, and build partnerships for implementation.
- **Develop quality standards and oversight mechanisms:** Establish quality standards for facilities and implement oversight mechanisms to promote continuous monitoring and quality improvement.
- **Implement workforce development programs:** Invest in training programs and recruitment strategies to attract and retain qualified staff, focusing on building a diverse and culturally relevant workforce.

3. Workforce Priorities

There is a national shortage of BH workers. Montana's rural and frontier geography exacerbates this shortage. Providers that are active in Montana serve populations who are widely dispersed and hard-to-reach. Montana has instituted changes to help address BH workforce shortages and make it easier for BH providers to deliver care to Montanans. In September 2021, DPHHS initiated a comprehensive provider rate methodology study for home- and community-based services in the State. The study revealed that Montana's Medicaid rates for providers were below benchmark standards based on actual cost of care. In June 2023, Governor Gianforte signed HB 2, which contained $339 million in rate increases for Medicaid providers, including BH providers, over the next two years. In addition, in 2023, the Legislature passed HB 101 and HB 137 to revise licensing and certification requirements for BH practitioners, including reciprocity provisions for out-of-state practitioners.

Figure 18 lists the three key initial Workforce recommendations with criteria weighting assignments and resulting priority scores.

Recommendations	Broad BH Ecosystem Impact	Subcommittee Priority	Investment Commitment	BHSFG Commission Priority	Implementation Complexity	Level of Effort	Initial Score
3.1 Create a dedicated provider recruitment and retention unit within state government to support expansion and maintenance of homegrown BH workforce.	High	Moderate	$$$	High	Moderate	High	21
3.2 Evaluate the sustainability of expanding the scope and/or use of ancillary providers (e.g., peer support specialists, community health workers, family caregivers) to deliver BH-related services and integrate these providers into BH care teams.	Moderate	Moderate	$$	Moderate	Moderate	Moderate	18
3.3 Enhance BH provider workforce capacity by ensuring Advanced Practice Registered Nurses (APRNs) have sufficient opportunity for training and clinical practice in BH, including delivery of BH services via telehealth.	Moderate	Moderate	$$	Moderate	Moderate	Moderate	18

Figure 18. Workforce Recommendations Scorecard

Recommendation 3.1. Create a dedicated recruitment and retention unit within state government to support expansion and maintenance of homegrown BH workforce.

As conveyed by BH providers in one-on-one listening sessions, there is opportunity for government organizations in Montana to lead the charge of a dedicated recruitment process in the State. Steering Committee members recounted experiences of facilities closing due to the inability to maintain or recruit a sufficient workforce, particularly in the less populous areas of the State. Additionally, Committee members mentioned a lack of housing, or lack of affordable housing for staff, resulting in excessive commute times for BH provider staff traveling to and from work.

Identifying and recruiting potential provider candidates who are native to Montana, or other rural/frontier states, would help to address the workforce recruitment and retention issue. To accomplish this task, the study team recommends that the State conduct a current state assessment to evaluate existing BH recruitment and retention activities within and outside of the State. From assessment findings, the State could develop a recruitment initiative to strategically recruit providers.

One recommendation is the development of a BH recruitment and retention unit. One recruitment tactic would be to build the future pipeline of people interested and trained in BH careers. This can include establishing career pipelines through high schools, community colleges, tribal colleges, vocational schools, and institutions of higher education to form partnerships that expand in-state awareness of various BH career opportunities. The recruitment and retention unit could also provide technical assistance to potential students on completing applications for scholarships, grants, and loans to pursue career opportunities in BH.

Factors Supporting the Recommendation

- **Addressing the talent gap:** Montana faces a critical shortage of BH professionals, particularly in rural and frontier areas. A dedicated recruitment and retention unit can focus on strategic efforts to attract and retain talent within the State, as well as recruit from outside entities. Initiatives can focus on both short-term and long-term recruitment and retention strategies.
- **Building a sustainable workforce:** Investing in statewide talent through scholarships, loan repayment programs, and targeted recruitment programs can create a pipeline of BH professionals familiar with the unique needs of Montana communities. Investments can be offered statewide but focused to meet clinical shortages and workforce gaps.
- **Offering robust training and education:** There is opportunity to invest in the BH workforce pipeline through academic and practical experience to prepare students to immediately enter the workforce and give BH employers the confidence that new hires are appropriately trained. These opportunities apply to both clinical and non-clinical workforce, including peer supports and non-licensed professionals who can extend service to behavioral healthcare users.
- **Reducing external recruitment and reliance on out-of-state support:** Dependence on out-of-state professionals is costly to sustain and access to care can fluctuate. Cultivating an in-state workforce with connections to Montana supports retention within existing organizations. Hiring from within communities fosters a sense of belongingness and adds to the cultural sensitivity.

- **Improving cultural competency:** By supporting local students and professionals, Montana can build a BH workforce that better reflects the cultural diversity of its communities and promotes culturally relevant care for all Montanans.

Quantitative Data that Informed the Recommendation

Utilizing Medicaid claims data has been instrumental in understanding utilization patterns of the current system of care across Montana's regions. This data, supported by feedback from stakeholders, highlights current State challenges in meeting the service needs.

Figure 19 shows how Region 1 exhibits some of the lowest BH provider staff employment rates, indicating an access or service gap resulting in unmet care needs. Region 1 mitigates shortages by leveraging other BH providers such as Behavior Analysts, non-Psychiatrists, and mid-levels.

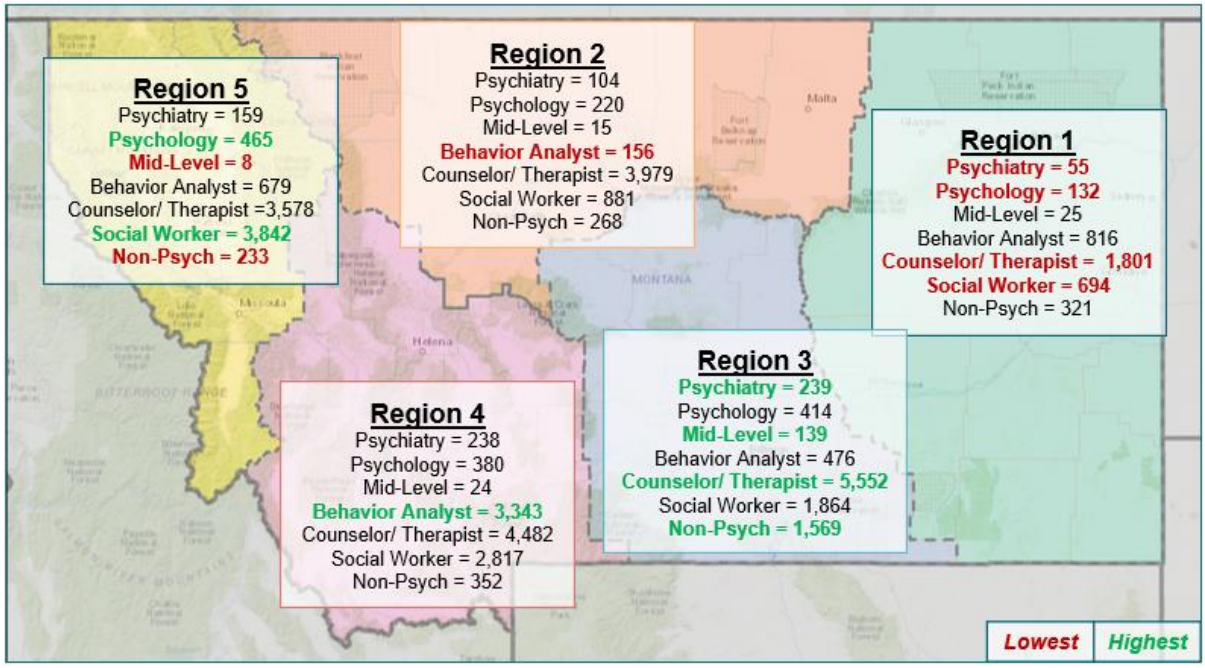


Figure 19. 2022 BH Provider Consults per 1,000 Medicaid Enrollees by Region

Anticipated Impact of the Recommendation

- **Increased access to BH services:** With more professionals employed in the State, particularly in rural and frontier areas, access to critical BH services can be significantly improved, reducing wait times, and addressing unmet care needs.
- **Enhanced quality of care:** A homegrown workforce familiar with Montana's specific culture and unique geography can provide tailored interventions.
- **Strengthened rural and frontier communities:** Having more BH professionals embedded in rural and frontier communities can increase access to timely BH care.

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that potential unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes stated above.

- **Sustainability of funding:** Long-term commitment and consistent funding are crucial for the success of recruitment and retention initiatives. Funding fluctuations could disrupt programs and undermine progress. A committed, long-term state initiative is essential to act upon this recommendation with appropriate empowerment of staff to engage and deploy resources such as financial incentives and repayment programs to draw professional talent.
- **Equity and access in scholarship programs:** Designing scholarship programs to promote equitable access for students from diverse backgrounds and rural and frontier communities is necessary to build a sustainable workforce.
- **Lack of awareness and support for scholarships:** Educational expenses may prohibit many from pursuing degrees or certifications. Promotion and awareness of scholarship programs can encourage individuals who may have previously not sought higher education or certifications, to pursue these educational opportunities. Investing in candidate pipeline partnerships will be critical to the success of the initiative.
- **Effective recruitment strategies:** Alongside pipeline development, tailored recruitment campaigns are needed to attract the right talent. A focus on the unique benefits of practicing in Montana and building strong partnerships with training institutions can be a strategy to increase recruitment.
- **Retention challenges:** Retention strategies should go beyond financial incentives. Providing mentorship, professional development opportunities, and creating supportive work environments are essential for retaining professionals.
- **Affordable housing:** Access to affordable housing for new BH provider staff could be a limiting factor. Rising housing costs (and overall cost of living) near job sites may inhibit recruitment efforts.

Recommended Next Steps

- **Perform a needs assessment to determine the feasibility of developing a BH Recruitment and Retention unit internally or externally and identify the appropriate governmental oversight branch:** The study team recommends that the State conduct a needs assessment to identify existing BH recruitment efforts within DPHHS, the Department of Labor and Industry through their Business and Education Engagement Team, Office of Commissioner of Higher Education/University of Montana, Montana Office of Public Instruction, Area Health Education Centers (AHEC), Behavioral Health Alliance of Montana, and third-party organizations. Based on assessment results, the State can determine the best approach to overseeing recruitment and retention efforts, whether it be government-agency led, or through a procurement process to contract with an entity to establish a dedicated BH recruitment and retention unit. The chosen entity will be responsible for allocating resources and personnel to effectively manage the recruitment and retention unit, ensuring program implementation, and tracking progress.
- **Develop a comprehensive recruitment plan:** The chosen entity will create a targeted list of schools to visit on a regular cadence; materials for distribution on potential careers and scholarship programs with clear eligibility criteria, loan repayment options, and incentives for professionals to practice in rural and frontier areas; and provide technical assistance in completing applications and follow-up job placement.
- **Develop a comprehensive retention plan:** The chosen entity will participate in regional and statewide BH professional meetings and continuing education sessions to obtain feedback on what is working and not working for providers in Montana and provide a

feedback line to respond to issues and develop solutions. They will also identify retention and career laddering opportunities to allow individuals to increase their skills and advance to higher levels of employment as they are completing required coursework through apprenticeships and training programs.

- **Collaborate with stakeholders:** The chosen entity may choose to partner with universities, BH professional associations, community organizations, and potential employers to develop tailored recruitment and training programs. In addition to some of the entities mentioned above, partnerships could be evaluated with the Montana Healthcare Workforce Advisory Committee, tribal colleges, the Department of Education, and the Health Occupation Students Association.
- **Secure funding and build partnerships:** The chosen entity will explore different funding sources, including federal grants, partnerships with private foundations, and collaborations with healthcare providers, using existing resources available in Montana. Potential funding opportunities for the program could include Pell Grants, Carl D. Perkins funding, student loans, Block Grants, HRSA funds, marijuana or alcohol taxes, or opioid settlement funds.
- **Monitor and evaluate the program:** The chosen entity should regularly assess the effectiveness of recruitment and retention initiatives, collect feedback from stakeholders, and adjust as needed to optimize results.

Recommendation 3.2. Evaluate the sustainability of expanding the scope and/or use of ancillary providers (e.g., peer support specialists, community health workers, family caregivers) to deliver BH-related services and integrate these providers into BH care teams.

The State can evaluate the sustainability and benefits of expanding the use of ancillary providers, such as peer support specialists, community health workers, and family caregivers. This may include extending eligibility of community health workers to receive Medicaid reimbursement for delivering certain services. This may also include expanding the scope of covered family caregiver services and covered peer services, such as group peer support and family peer support. As part of this recommendation, the State can define Medicaid reimbursable services that could be provided by the ancillary providers, review qualifications for enrollment with Medicaid, and develop policy for more widely integrating these types of ancillary providers into BH care teams. The evaluation may consider estimated utilization of these ancillary provider types, estimated impact on access to care, and resulting effect on the Medicaid budget.

Factors Supporting the Recommendation

- **Filling the gap:** Traditional BH professionals are in short supply, particularly in rural and frontier areas of Montana. Ancillary providers such as peer support specialists, community health workers, and family caregivers can address the gap by offering readily available support, education, and advocacy.
- **Unique perspectives:** Ancillary providers bring lived experience and community knowledge that enhances understanding and trust with individuals receiving care. Peer support specialists, for example, can share strategies for coping and recovery, while family caregivers can provide invaluable practical and emotional assistance.
- **Holistic care:** Integrating ancillary providers promotes a team-based approach, allowing for comprehensive care encompassing not just clinical aspects but also SDoH, such as housing and financial security.

- **Cost-effectiveness:** Utilizing non-licensed workforce, such as family caregivers, can be more cost-effective than relying solely on specialized professionals. This allows resources to be maximized and reach more individuals.

Quantitative Data that Informed the Recommendation

The current BH delivery system in Montana, and throughout the country, faces a significant shortage of traditional BH providers. The existing shortage leaves numerous individuals struggling to access the care they need. Table 5 shows the total supply of traditional BH providers throughout the State.

Table 5. 2022 BH Provider Consults/1,000 Medicaid Enrollees by Region

BH Provider Types	Region 1	Region 2	Region 3	Region 4	Region 5	Montana
Psychiatric Providers	1.3	6.6	14.5	16.4	11.7	12.2
Advanced Practitioners	1.3	1.3	5.7	2.9	3.2	3.3
Psychologists	5.2	14.5	11.9	15.5	26.0	17.2
SWs/Counselors/Therapists	62.8	120.0	167.5	193.6	223.0	178.2
Total	**70.7**	**142.4**	**199.7**	**228.4**	**263.9**	210.8
Total Supply	54	216	453	709	903	2,335
% of MT Supply	2.3%	9.3%	19.4%	30.4%	38.7%	100.0%
Population (2022)	76K	152K	227K	310K	342K	1.1M
% of MT Population	6.9%	13.7%	20.5%	28.0%	30.9%	100.0%

Table Note: Cells shaded red represent the region(s) with the lowest number. Cells shaded green represent the region with the highest number.

Qualitative Data that Informed the Recommendation

Stakeholders proposed that extending the scope of practice of ancillary providers and integrating them into BH care teams, will enable Montana to unlock a powerful resource to address this critical gap. Additionally, the integration of ancillary providers into BH care teams presents a potential solution to the provider shortage. Ancillary providers offer diverse perspectives, lived experiences, increased capacity, and hold the potential to significantly improve access to quality care, enhance cultural competency, and optimize individual and community well-being.

Anticipated Impact of the Recommendation

- **Increased access to BH services:** Expanding the scope of practice and integrating ancillary providers can reach underserved populations in Montana, particularly in rural and frontier areas and among ethnic/cultural minorities.
- **Improved treatment outcomes:** Studies show that peer support and community-based interventions can be as effective as traditional therapy in some cases and can even lead to improved medication adherence and reduced symptom severity.
- **Enhanced individual engagement and satisfaction:** Individuals may feel more comfortable and understood by ancillary providers who share similar experiences or

cultural backgrounds. This can lead to increased engagement and/or satisfaction in treatment and better overall outcomes for the individual receiving care.[38]

- **Strengthened community resilience:** Building bridges between the formal BH system and community resources can foster a more supportive and responsive environment for individuals seeking care.
- **Embedded culturally relevant care:** Utilizing ancillary providers allows for the delivery of BH services in a way that is familiar and supportive to the individual, incorporating traditions and healing strategies. (e.g., in Tribal populations, the incorporation of sweat lodges and smudging).

Considerations of the Recommendation

Should the State elect to implement this recommendation, Montana must ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above.

- **Scope of practice limitations:** Carefully defining the appropriate scope of practice for ancillary providers is crucial to promote the safety and quality of care. Clear training and supervision guidelines are essential.
- **Professional credentialing and reimbursement:** Integrating ancillary providers effectively may require changes in licensing and reimbursement structures to promote fair compensation and recognition of their skills. A future study on the potential budgetary impact would need to occur to determine the cost of expanding the usage of these ancillary providers.
- **Burnout and sustainability:** Providing ongoing training, support, and supervision for ancillary providers is crucial to prevent burnout and promote their long-term engagement in the BH system.
- **Cultural barriers:** Ensuring cultural competency among ancillary providers is essential to effectively serve diverse populations in Montana. (e.g., community, spiritual, religious, and Tribal leaders).

Recommended Next Steps

- **Develop training and certification programs:** Create culturally responsive training programs for ancillary providers, with clear guidelines on their roles and responsibilities within the BH care team.
- **Pilot programs and evaluation:** Implement pilot programs in different communities to test different models of integrating ancillary providers and evaluate their effectiveness and feasibility.
- **Build partnerships:** Create partnerships with community organizations, faith-based groups, and educational institutions to leverage existing resources and support the development of a sustainable workforce of ancillary providers.
- **Database of ancillary providers**: Develop a database of ancillary providers and their locations, to alert care coordinators of the location and roles of ancillary providers to reach out to for support.

[38] "Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies, June 2014 | National Association of State Mental Health Program Directors," 2014, https://www.nasmhpd.org/content/new-samhsa-publication-crisis-services-effectiveness-cost-effectiveness-and-funding.

Recommendation 3.3. Enhance BH provider workforce capacity by ensuring Advanced Practice Registered Nurses (APRNs) have sufficient opportunity for training and clinical practice in BH, including delivery of BH services via telehealth.

The State can help to enhance BH provider workforce capacity and improve the health of Montanans by preparing APRNs to deliver high-quality behavioral healthcare, including BH services delivered by telehealth. Because there is an increasing demand for BH telehealth and because there are different methods and competencies associated with delivering BH services in a virtual manner, the study team recommends that the State ensure that APRNs receive enhanced BH training specific to telehealth as part of course curriculum and practical training. Training may cover topics such as telehealth security and privacy, clinical engagement over telehealth, and workflows and safety planning via telehealth.

Montana State University already offers a postgraduate psychiatric MH nurse practitioner (NP) certificate to credential and certify APRNs as Psychiatric Mental Health Nurse Practitioners.[39] Programs such as Montana State University's psychiatric MH NP certificate program could include specific training around delivering virtual BH services to individuals with BH conditions and providing telehealth consultations. To create further incentive for APRNs to obtain additional BH training, the State could provide financial support for students through grant opportunities to achieve such a certificate and/or sponsor avenues for APRNs and other provider types to receive telehealth training as part of continuing education requirements.

The State can also clarify the scope of practice for APRNs to include permitted activities specific to telehealth, modeled after Administrative Rules of Montana 24.156.813, Practice Requirements for Physicians and Physician Assistants Using Telemedicine.[40] Clarifying the APRN scope of practice related to telehealth can help to avoid misinterpretation over the services APRN can or cannot offer (e.g., psychiatric assessments via telehealth) so that APRNs are not inadvertently limited from offering critical services via telehealth.

Factors Supporting the Recommendation

- **Expanded access to behavioral healthcare:** APRNs can play a crucial role in addressing the psychiatric care shortage, responding to community BH needs, and enhancing the skills of NPs in psychiatric care. Further, training in telehealth consultation and virtual BH services can help expand use of providers specifically trained to deliver BH services via telehealth. This, in turn, can increase access to BH services, especially in rural and frontier areas of Montana where specialists are scarce.
- **Specialized expertise:** Not all BH conditions require a psychiatrists' expertise. Psychiatric Mental Health NPs are trained to conduct an array of BH assessment and treatment services.
- **Enhanced collaboration:** Telehealth facilitates collaboration between various BH professionals involved in an individual's care. Psychiatric Mental Health NPs focusing on telehealth can consult with psychiatrists for reviewing individuals' assessments, treatment plans, and medication management.

[39] "Postgraduate Psychiatric Mental Health Nurse Practitioner Certificate," Montana State University, https://www.montana.edu/nursing/graduate/psychiatric-mental-health-nurse-practitioner-certificate.html.

[40] "Practice Requirements for Physicians and Physician Assistants Using Telemedicine," Montana Secretary of State, https://rules.mt.gov/gateway/RuleNo.asp?RN=24%2E156%2E813.

Qualitative Data that Informed the Recommendation

During stakeholder meetings, the need to expand the use of non-psychiatrist providers to conduct telehealth appointments to alleviate the challenges posed by provider shortages was a recurring theme. Stakeholders highlighted several pain points associated with this issue:

- **Limited access to timely care:** Lengthy wait times for psychiatric evaluations create significant barriers to receiving critical BH support.
- **Geographic disparities:** Psychiatrist shortages disproportionately impact rural and frontier areas, leaving individuals with limited access to specialized care.
- **Increased burden on EDs:** Unmet BH needs often translate to unnecessary ED visits, straining already stretched resources.

Stakeholders identified telehealth as a promising solution but recognized the limited availability of psychiatrists capable of utilizing this platform for assessments and ongoing appointments. Consequently, many members expressed support for exploring the training of additional non-psychiatrist providers to conduct telehealth consultations and appointments.

Anticipated Impact of the Recommendation

- **Reduced health disparities:** Increased access to behavioral healthcare, including telehealth consultations with physical health providers and behavioral healthcare delivered through telehealth, can address the existing disparities in rural and frontier and underserved communities in Montana. Early intervention and timely support can improve overall health outcomes.[41]
- **Improved convenience:** Telehealth eliminates the need for long travel distances, which can make behavioral healthcare more accessible and convenient, especially for those with mobility limitations or transportation barriers.
- **Greater treatment adherence:** Improved accessibility can lead to increased adherence to treatment plans and better management of BH conditions.
- **Cost savings for the healthcare system:** By expanding access and promoting early intervention, telehealth can potentially reduce long-term healthcare costs associated with untreated or poorly managed BH conditions.

Considerations for the Recommendation

Should the State elect to implement this recommendation, Montana will need to ensure that unresolved risks do not hamper the efficacy of the recommendation in achieving anticipated outcomes above.

- **Quality of care:** Ensuring high quality telehealth consultations and virtual BH services requires clear guidelines, additional training, and robust telehealth platforms with secure technology.

[41] Substance Abuse and Mental Health Services Administration (SAMHSA). “Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.” SAMHSA Publication No. PEP21-06-02-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.

- **Technological access and literacy:** Telehealth accessibility depends on reliable internet connectivity and digital literacy, which may exacerbate existing disparities in rural and frontier and underserved communities.
- **Legal and ethical considerations:** Issues of privacy, confidentiality, and informed consent need to be carefully addressed in a telehealth setting.

Recommended Next Steps

- **Develop training standards:** Clearly define the training requirements for Psychiatric Mental Health NPs, including training standards specific to telehealth. Consider telehealth training requirements as part of licensing requirements. Establish rigorous training programs to promote competency and adherence to best practices.
- **Pilot programs and evaluation:** Design and implement a telehealth training program, leveraging existing curriculum from other national bodies, to help address Montana's workforce needs. Identify metrics and milestones to evaluate the impact on workforce, access, and quality.
- **Expand internet access and digital literacy:** Address the digital divide by collaborating with telecommunications providers and community organizations to improve internet infrastructure and provide digital literacy training in rural and frontier and underserved areas.
- **Invest in secure telehealth platforms:** Ensure the adoption of secure telehealth platforms that comply with Health Insurance Portability and Accountability Act regulations and address potential privacy and security concerns.

Appendix A. Preliminary Cost Estimates

As outlined in the Access Priorities Findings and Recommendations, the study team recommends that the State offer additional acute, sub-acute, and OP facilities strategically located across Montana to improve behavioral healthcare access. Based on discussions with Steering and Subcommittee members and detailed analysis of claims data, the study team identified gaps in BH services in each region of the State. Figure 20 illustrates the proposed Comprehensive Behavioral Healthcare Campuses (Recommendation 2.2) and associated service needs proposed to be located within each care site catchment area in each region. One approach to address these service gaps is for partnership among existing healthcare facilities to retrofit their infrastructure to support care delivery in the identified service areas. Additionally, if partnerships are not available, new construction can be leveraged to develop infrastructure to provide the services outlined.

To support the access recommendations outlined in the report, the study team developed directional cost estimates that provide:

- Rough Order of Magnitude (ROM) construction cost range for new construction for the proposed Comprehensive Behavioral Healthcare Campuses (Table 6)
- ROM cost per square foot range for new construction for ambulatory / sub-acute care (Table 7)
- ROM cost per square foot retrofit range for ambulatory / sub-acute care (Table 8)
- ROM cost per square foot retrofit estimate range for acute care (Table 9)

The estimates shown are ROM estimates only, intended to provide an initial approximate view of potential relative costs for proposed opportunities. The study team prepared estimates consistent with general industry standards in line with Association for the Advancement of Cost Engineering (AACE) Class-5 estimates. The study team developed these cost estimates, leveraging average healthcare construction costs in Montana, RSMeans construction estimating software, Turner Construction Cost Index, Dodge Data Analytics, Construction Cost Handbook, FGI Guidelines, comparable size and capacity standards for each facility, and associated gaps in services.

Cost Estimate Limitations

The estimates should not be relied upon for making critical / investment decisions. The cost estimates are intended for preliminary, high-level planning discussions and did not leverage detailed project scope or conceptual design. ROM estimates are subject to change and may vary significantly as more information becomes available, project specifics are defined, and market conditions change. Furthermore, the estimates do not account for all potential variables and unforeseen factors that may impact the actual cost of a project.

These estimates do not consider specific BH facility parameters, land acquisition, site work, furnishing, design and engineering, co-location licensing parameters, nor detailed programming. These estimates are meant to be used for relative / directional discussions as the State and the BHSFG Commission consider various recommendations to address the identified BH service gaps in the State. As future solutions move towards implementation, detailed cost estimates should be completed to inform individual project requirements.

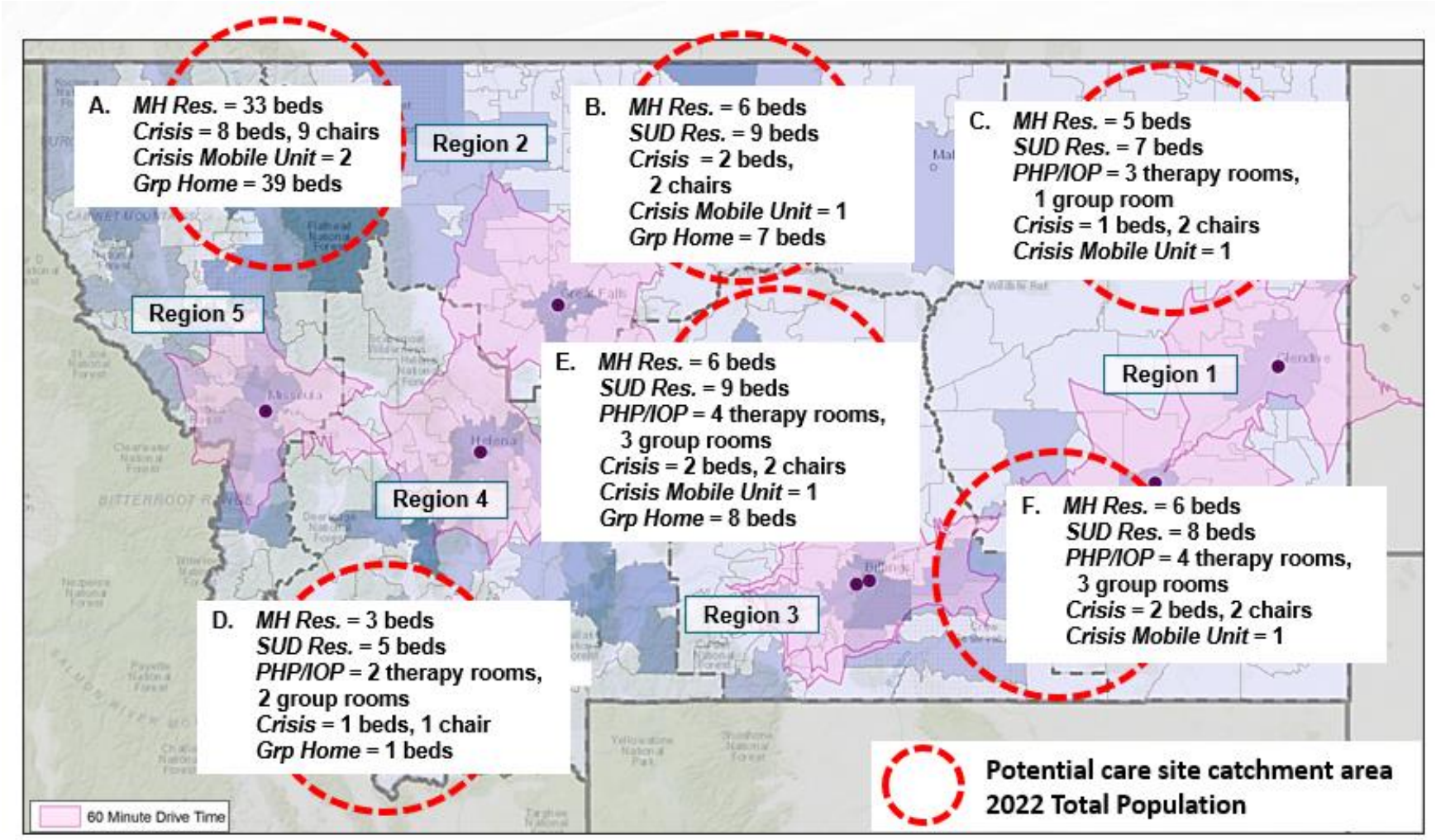


Figure 20. Proposed Comprehensive Behavioral Healthcare Campuses

Table 6. Estimated New Construction Costs: Proposed Comprehensive Behavioral Healthcare Campuses

	Estimated New Construction Costs: Proposed Comprehensive Behavioral Healthcare Campuses					
	A	**B**	**C**	**D**	**E**	**F**
Mental Health Residential Estimated Bed Needs	33	6	5	3	6	6
Substance Use Disorder Residential Estimated Bed Needs	-	9	7	5	9	8
Partial Hospitalization Program *(PHP)* Intensive Outpatient Program *(IOP)* Estimated Room Needs	-	-	4	4	7	7
Crisis Services Estimated Bed Needs	8	2	1	1	2	2
Group Home Estimated Bed Needs	39	7	-	1	8	-
ROM Total Square Footage Needs to Support Service Gaps	~42,100	~15,100	~12,100	~9200	~18,900	~15,700
ROM Estimate New Construction Cost for Non-Inpatient BH Services	$16.3M - $30.3M	$5.7M - $10.6M	$4.3M - $8.1M	$3.7M - $6.9M	$6.7M - $12.5M	$5.6M - $10.3M

Table Note: The following facilities / items are excluded from the cost estimate: Crisis Mobile Unit Fixtures and Furniture. Data sources include average healthcare construction costs in Montana, RSMeans construction estimating software, Turner Construction Cost Index, Dodge Data Analytics, Construction Cost Handbook, FGI Guidelines, comparable size and capacity standards for each facility, and associated gaps in services.

Square Foot Cost Estimate Summary by Care Setting

Table 7, Table 8, and Table 9 provide further detail on the cost per square foot estimates by care setting: ambulatory / subacute (new construction), ambulatory / subacute (retrofit), and acute (retrofit).

Table 7. ROM Ambulatory / Subacute New Construction (Greenfield Site) Estimates

Ambulatory / Subacute Cost / Sq. Ft - Greenfield Site	
Mental Health Residential	$280 - $520
SUD Residential	$280 - $520
Partial Hospitalization Program Intensive Outpatient Program	$245 - $455
Crisis Services	$245 - $400
Group Home	$150 - $300

Table 8. ROM Ambulatory / Subacute Retrofit Estimates

Ambulatory / Subacute Cost / Sq. Ft - Retrofit	
Mental Health Residential	$500 - $930
SUD Residential	$500 - $930
Partial Hospitalization Program Intensive Outpatient Program	$440 - $820
Crisis Services	$440 - $820
Group Home	$285 - $530

Table 9. ROM Acute Cost Retrofit Estimates

Acute Cost / Sq. Ft - Retrofit	
Inpatient Behavioral Health Facility	$550 - $850

Appendix B. Data Analysis Summary

Appendix B summarizes the analyses and information gathered during the design study to aid in gaining an understanding of the current state of Montana's BH ecosystem. The design study examined data and information from four dimensions:

1) Demographic profile of Montana and prevalence of BH conditions across the State
2) Physical access to BH services across Montana's health planning regions
3) Availability of BH workforce across Montana's health planning regions
4) Effectiveness of Montana's behavioral healthcare continuum, with a focus on care coordination across entities involved in the ecosystem.

Findings from the analysis of information and data in these four dimensions are summarized at the end of each section of Appendix B. The collective findings provide a snapshot of key challenges in Montana's ecosystem that must be addressed. The findings also informed the recommendations outlined in the Findings and Recommendations section of the report.

Overview of Need for BH Services in Montana

Montana's Geography

Montana has several unique features that differentiate it from other states. It has a comparatively large land mass with low population density and a higher-than-average Native American population. To profile and analyze data to inform the current state of Montana's BH ecosystem, the design study applied the five health planning regions utilized by DPHHS. The application of the five health planning regions facilitated understanding of regional nuances that impact residents' utilization of the BH ecosystem. The health planning regions are shown in Figure 21.[42]

Figure 21. Montana Health Planning Regions

Table 10 shows the alignment of counties to regions.

[42] "Health Planning Regions," n.d., https://dphhs.mt.gov/qad/licensure/healthcarefacilitylicensure/certificateofneed/healthplanningregions.

Table 10. Region to County Relationships[43]

Region	Counties
Region 1	Sheridan, Daniels, Valley, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River, and Carter
Region 2	Blaine, Hill, Liberty, Toole, Glacier, Phillips, Pondera, Teton, Chouteau, and Cascade
Region 3	Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn
Region 4	Lewis and Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park, Gallatin, Madison, and Beaverhead
Region 5	Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli

Montana's Population Demographics

As of 2023, Montana's population includes just over one million residents. Table 11 shows the 2022 population for each Montana health planning region along with the population's compound annual growth rate (CAGR) for 2022 through 2027.

Table 11. Population and Compound Annual Growth of each by Health Planning Region[44]

Region	2022 Population'	CAGR '22-'27
Region 1	76,431	0.04%
Region 2	151,661	0.1%
Region 3	226,890	0.5%
Region 4	310,361	0.9%
Region 5	342,161	0.8%
Montana	1,107,504	0.6%
United States	335,707,897	0.2%

A key step in building a thorough understanding of Montana's BH needs was understanding the current and projected population characteristics of the State using demographic information published by DPHHS and ESRI Data from 2022-2027. Figure 22 shows Montana's 2022 population, stratified by age and by health planning region.

[43] *Ibid*

[44] DPHHS website, ESRI Data 2022-2027.

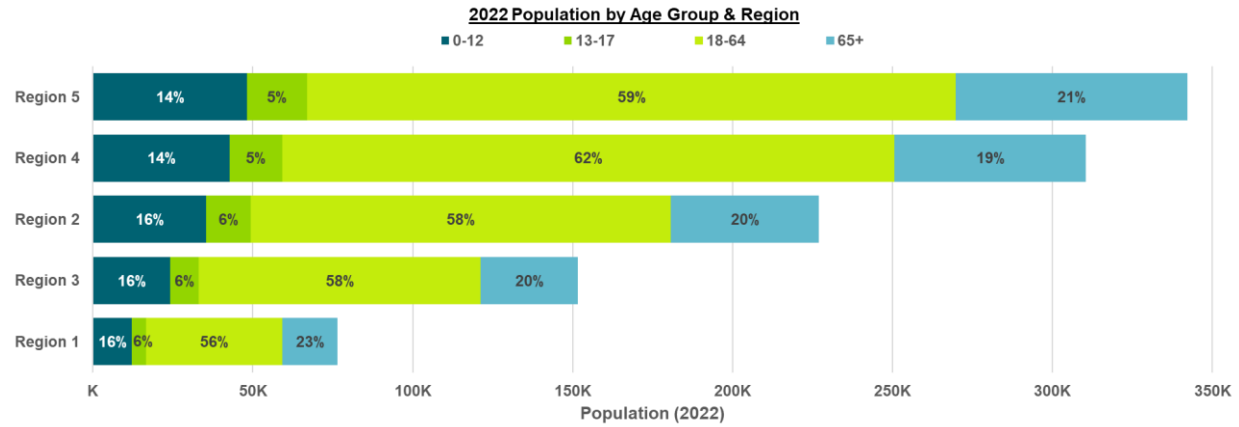


Figure 22. 2022 Population by Age Group and Region[45]

Figure Note: Percentages are rounded to the nearest whole number.

As the study team considered BH service provision, drilling down to understand the key features of each health planning region in Montana in terms of population demographics was a crucial step in the analyses process. Of note, the east-south and north geographical regions of Montana have distinct geographic and demographic qualities. They have low population density as well as larger Native American and Medicaid populations, which must be considered when designing a future that strengthens access to BH care due to reported challenges in access to such care.

Figure 23 illustrates the demographic uniqueness of each region. Region 1 has the lowest population density, high Medicaid utilization, high disability, and high Native American population. As seen later in this section, individuals living with BH conditions in Region 1 are more likely to travel further distances to receive care. Regions 1 and 2 have a high proportion of Native Americans. BH service needs in the regions must include consideration of cultural nuances and opportunities to collaborate with IHS and other tribal health partners.

2022 Service Area Demographics

Region/ Benchmark	Total Pop '22	Pop. CAGR '22-'27	Pop. Density / sq. mi.	Medicaid* N (% Pop.)	Disability** N (% Pop.)	Justice Sys.*** N (% Pop.)	% Native Am. N (% Pop)
Region 1	76,431	0.04%	1.8	**31.1%** (23.6K)	**14.7%** (11.3K)	**0.6%** (0.5K)	**14.1%** (10.7K)
Region 2	151,661	0.1%	5.2	**34.5%** (52.2K)	**13.9%** (21.1K)	**0.9%** (1.4K)	**16.0%** (24.3K)
Region 3	226,890	0.5%	8.3	**29.0%** (65.5K)	**12.6%** (28.6K)	**0.6%** (1.4K)	**7.4%** (16.9K)
Region 4	310,361	0.9%	10.8	**21.5%** (66.0K)	**12.2%** (37.8K)	**0.8%** (2.5K)	**1.4%** (4.4K)
Region 5	342,161	0.8%	17.9	**28.9%** (99.4K)	**15.0%** (51.3K)	**0.2%** (0.8K)	**3.7%** (12.8K)
Montana	1,107,504	0.6%	7.6	**27.8%** (306.8K)	**13.6%** (150.1K)	**0.6%** (6.6K)	**6.2%** (69.0K)
United States	335,707,897	0.2%	95.1	**28.3%** (94.8M)	**12.9%** (43.2M)	**0.6%** (2.1M)	**1.1%** (3.8M)

Significant variation noted

Figure 23. Demographic Characteristics by Region[46]

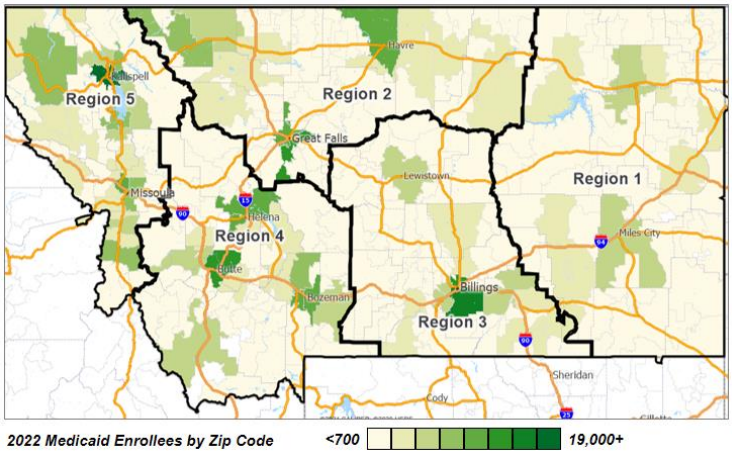
Figure 24 shows the geographic confluence of Medicaid enrollees in more populated regions, where major crossroads intersect within regions. When comparing the distribution of Medicaid

[45] *Ibid.*

[46] DPHHS website, ESRI Data 2022-2027, Disability Compendium 2019.

enrollees directly to population, Region 4 shows the greatest negative difference (22% vs. 28% of Montana's total population) and Region 2 shows largest positive difference (17% vs. 14% of Montana's total population).

As the study team considered where service investment should be prioritized, understanding population distribution and Medicaid enrollment patterns informed a picture of where client needs are most likely to exist, at present and into the future.



MT Regions	2022 Medicaid Enrollees	2022 Enrollees Distribution	2022 MT Population Distribution
Region 1	24K	8%	7%
Region 2	52K	17%	14%
Region 3	66K	21%	20%
Region 4	66K	22%	28%
Region 5	99K	32%	31%
Total	307K	100%	100%

Figure 24. Medicaid Enrollees by Region[47]

Montana's BH Needs

Population health outcomes help to inform a more comprehensive understanding of Montana's need for improved and increased BH services. Montanans consistently experience BH conditions at higher rates than the national average, as shown in Figure 25.

[47] Clarivate (Medicaid + Dual Eligible enrollees)

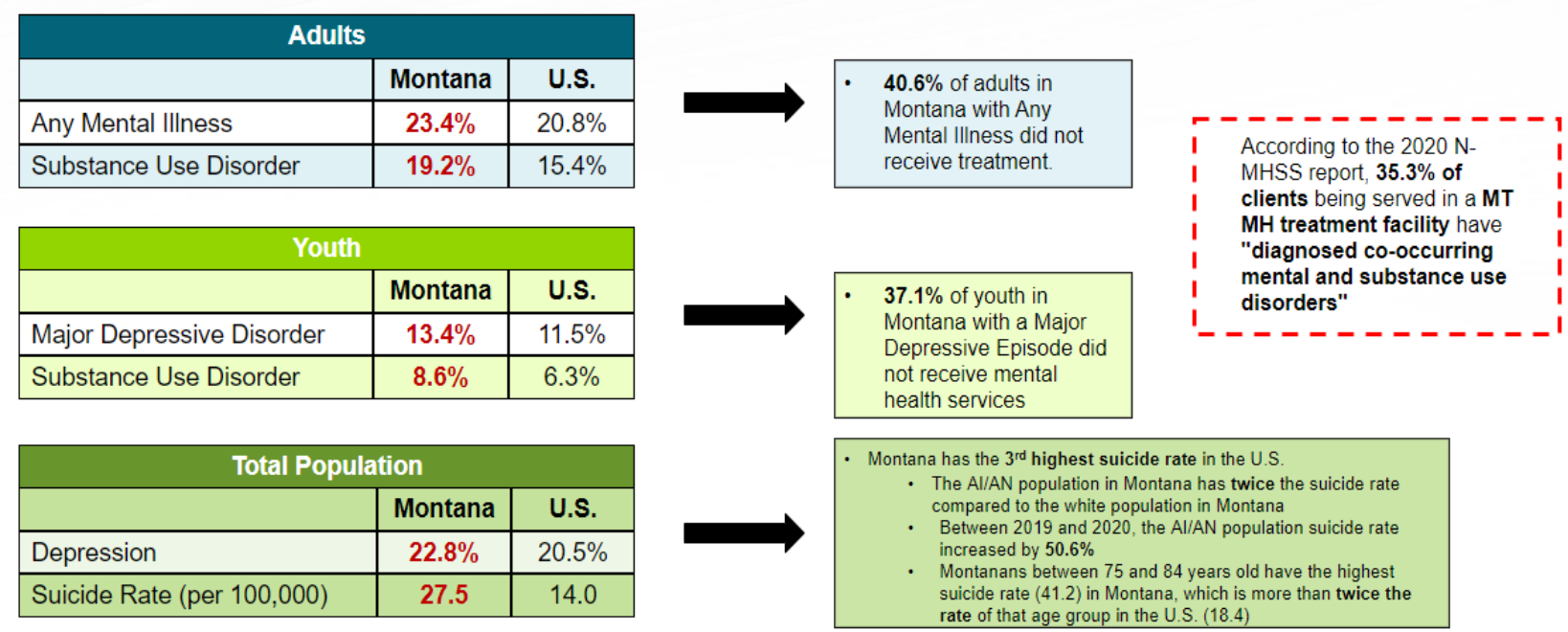


Figure 25. Montana BH Issues Prevalence[48,49,50]

Montana's suicide rate is the third highest in the United States and is twice the US average as shown in Figure 26. The AI/AN population has twice the suicide rate when compared with the white population in Montana, suggesting Tribal communities are at particular risk.

[48] "Prevalence Data 2023," Mental Health America, 2023, https://mhanational.org/issues/2023/mental-health-america-prevalence-data.

[49] America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation, AmericasHealthRankings.org, https://www.americashealthrankings.org/explore/measures/Suicide/MT

[50] America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, https://www.americashealthrankings.org/explore/measures/Depression_a/MT

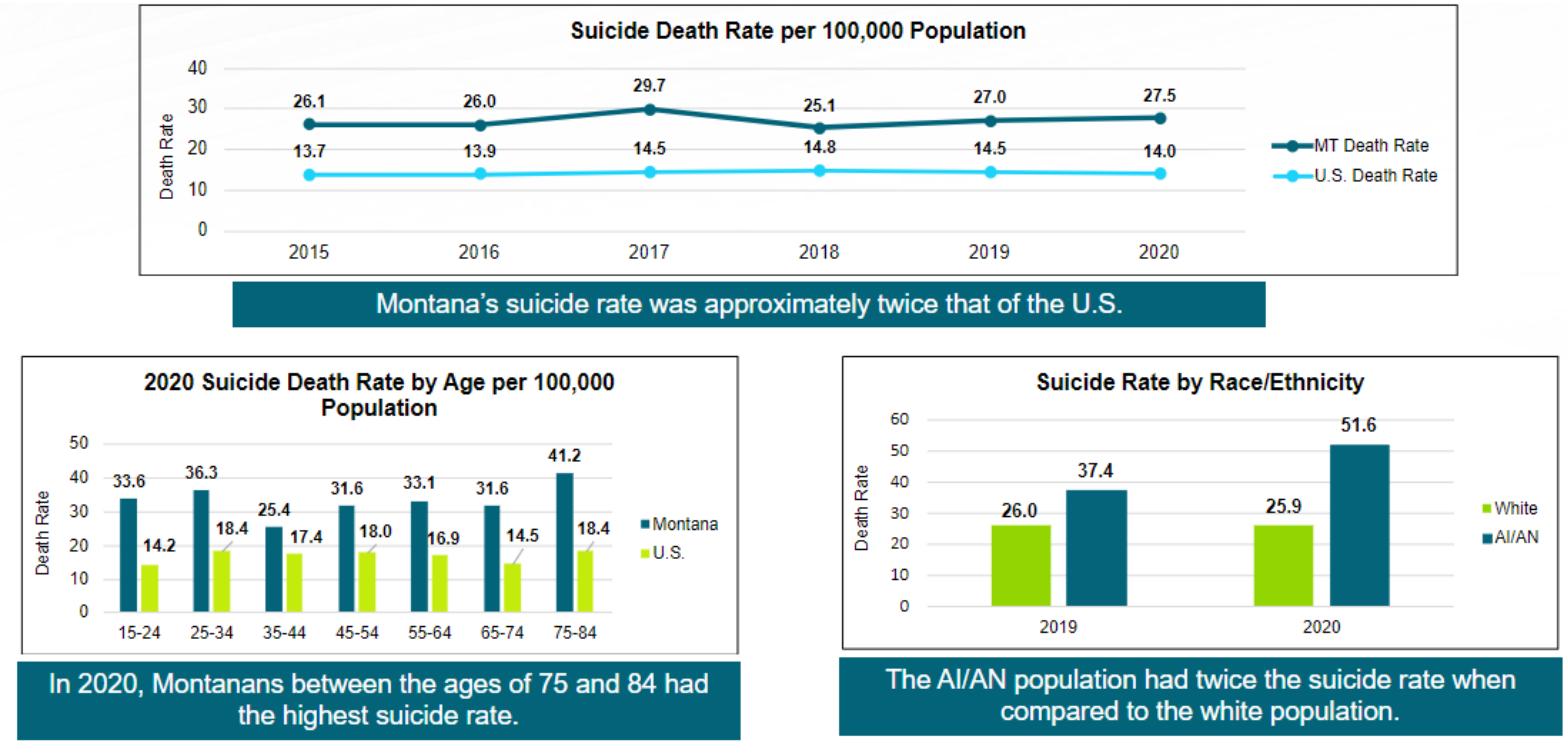


Figure 26. Montana Suicide Rates Compared to National Averages[51]

Apart from rates of suicide, adults and youth in Montana have a higher percent of Any Mental Illness (AMI), Major Depressive Episodes (MDE), and Substance Abuse Disorders (SUD) when compared to the United States (see Figure 27). Additionally, between 2015-2021, the number of drug overdose deaths in Montana increased by 44.2%, shown in Figure 27. The summation of these demographic outcomes raises concern that the overall BH of residents of Montana is trending in the wrong direction.[52,53]

[51] America's Health Rankings analysis of CDC WONDER

[52] "Prevalence Data 2023."

[53] "Drug Overdose Mortality by State," Data set (Center for Disease Control and Prevention (CDC), 2020), https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm.

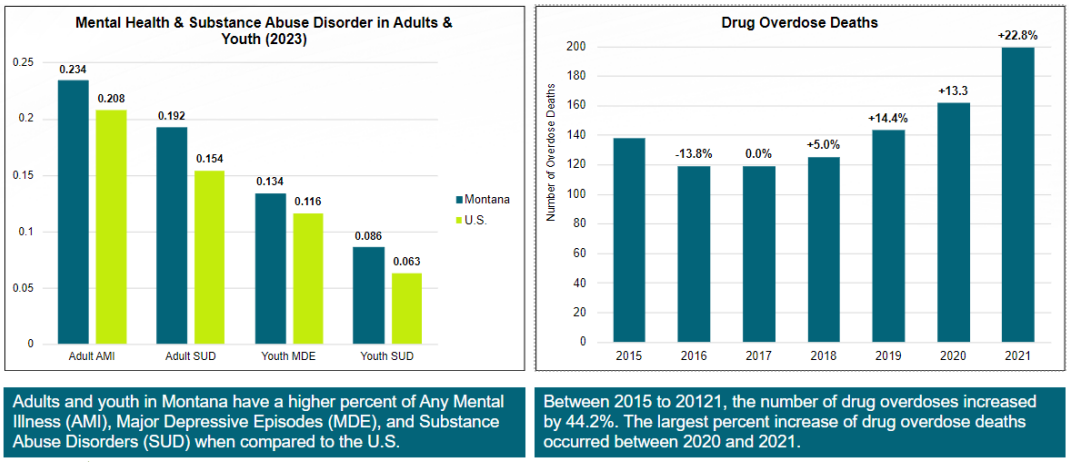


Figure 27. Montana BH Condition Rates and Trends

Research, supplemented by data analysis findings, suggests the prevalence of BH conditions among residents in Montana is reinforced by statewide limitations in access to BH services. A snapshot of BH in Montana, as outlined in Figure 28, shows that 52.1% of residents in Montana live in a community that does not have sufficient BH providers to meet the community's need, suggesting a strong, statewide need for improved access to behavioral healthcare providers.[54]

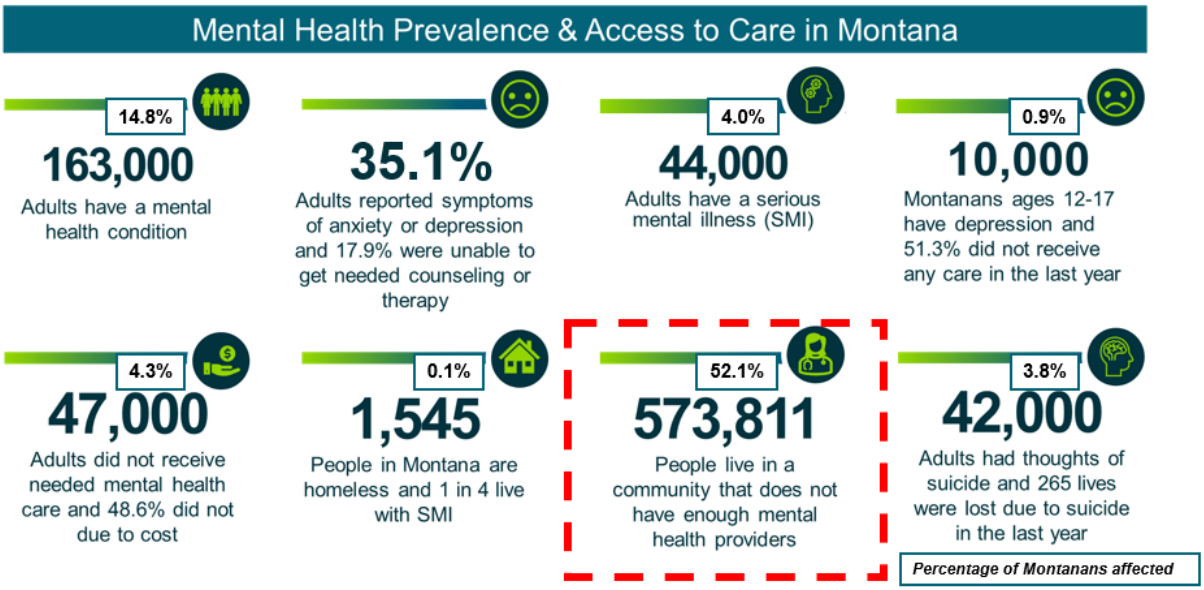


Figure 28. Prevalence and Access to Behavioral Healthcare[55]

Montana's Behavioral Healthcare Delivery System

To better understand Montana's BH prevalence and current access limitations, the study team considered Montana's BH outcomes in the context of regional and peer state performance. This study included examination of key indicators of BH compared between Montana and states of

[54] "Mental Health in Montana," *National Alliance on Mental Illness (NAMI)* (National Alliance on Mental Illness (NAMI), February 2021), https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MontanaStateFactSheet.pdf.

[55] *ibid*

similar geographic and demographic make-up. These states included Idaho, North Dakota, Oregon, South Dakota, and Wyoming.

Table 12 illustrates that Montana performs at the lower end of several BH rankings and outcomes as compared to peer states. Montana ranks low in substance use and pediatric rankings. Montana is ranked 29th in the US in access to adult BH services. In the wider context of the region, Montana shows mixed performance across BH outcomes, with deficits in suicide rates, SUD prevalence, and pediatric BH condition prevalence.[56,57]

Table 13 shows a comparative assessment of State BH service management including access, continuum of care, and workforce. While Montana's Medicaid program parameters align with peer state's Medicaid programming, both adults and pediatrics in Montana have higher rates of BH conditions and need for care, as noted in the *Access* row of TTable 13.

[56] "Prevalence Data 2023."

[57] "America's Health Rankings | AHR," America's Health Rankings, n.d., https://www.americashealthrankings.org/.

Table 12. State Comparisons – BH Rankings and Outcomes - 2023[58,59,60]

Topics	Montana	Wyoming	South Dakota	North Dakota	Idaho	Oregon
Population '23	**1,122,044**	**578,766**	**910,839**	**793,128**	**1,955,585**	**4,335,082**
Pop / Sq. Mi. '23	**7.7**	**6.0**	**12.0**	**11.5**	**23.7**	**45.2**
Adult* (overall) *Rank*	29	50	40	24	44	48
Adult (SMI) *(% Pop.)*	7.0%	6.7%	6.7%	7.1%	6.9%	6.5%
Adults w/ SUD* *Rank (% Pop.)*	50 (19.2%)	43 (17.6%)	47 (18.6%)	29 (16.4%)	17 (15.0%)	49 (19.1%)
Pediatric * (overall) *Rank (% Pop.)*	39	17	25	18	47	51
Pediatric w/ SUD* *Rank (% Pop.)*	50 (8.6%)	35 (6.9%)	43 (7.4%)	27 (6.5%)	38 (7.1%)	49 (8.0%)
Access** *Rank*	4	41	12	18	35	30
Suicide*** *Rank (#/ 100K)*	48 (27.5)	50 (31.8)	43 (21.4)	32 (18.0)	46 (23.6)	38 (19.2)
MH Providers**** *Rank (#/ 100K)*	16 (360.9)	13 (390.3)	39 (220.7)	38 (225.0)	33 (246.3)	3 (654.1)

Table Note: *Adult and Youth Overall: Includes measures around prevalence of mental illness and access to care; ** Access: Includes measures around access to insurance and mental health treatment; ***Suicide: Deaths due to intentional self-harm per 100K population; ****MH Providers: Number of psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental healthcare.

Table 13. State Comparison of BH Program Outcomes

Topic Area	Montana	Wyoming	South Dakota	North Dakota	Oregon
Medicaid Infrastructure	• Medicaid Expansion State • Fee for Service • **Medicaid % Pop. = 19.8%** • **Medicaid N = 328.5 K**	• Non-Medicaid Expansion State • Fee for Service • **Medicaid % Pop. = 11.5%** • **Medicaid N = 84.5 K**	• Medicaid Expansion State • Fee for Service • **Medicaid % Pop. = 13.8%** • **Medicaid N = 147.0 K**	• Medicaid Expansion State • <50% Managed Care Models • **Medicaid % Pop. = 9.8%** • **Medicaid N = 133.3 K**	• Medicaid Expansion State • <50% Managed Care Models • **Medicaid % Pop. = 23.8%** • **Medicaid N = 1.4 M**
Access	• **Share of adults** in 2018-2019 with **any mental illness covered by Medicaid**: **29.3%** • Percent of **pediatrics who received any treatment** or counseling from a MH professional in 2022: **14.4%**	• **Share of adults** in 2018-2019 with **any mental illness covered by Medicaid**: **12.6%** • Percent of **pediatrics who received any treatment** or counseling from a MH professional in 2022: **14.8%**	• **Share of adults** in 2018-2019 with **any mental illness covered by Medicaid**: **12.1%** • Percent of **pediatrics who received any treatment** or counseling from a MH professional in 2022: **12.0%**	• **Share of adults** in 2018-2019 with **any mental illness covered by Medicaid**: **21.4%** • Percent of **pediatrics who received any treatment** or counseling from a MH professional in 2022: **14.6%**	• **Share of adults** in 2018-2019 with **any mental illness covered by Medicaid: 22.1%** • Percent of **pediatrics who received any treatment** or counseling from a MH professional in 2022: **13.8%**
Continuum of Care	• **Adults reporting unmet need** for MH treatment in 2018-2019: **5.4%**	• **Adults reporting unmet need** for MH treatment in 2018-2019: **6.5%**	• **Adults reporting unmet need** for MH treatment in 2018-2019: **5.4%**	• **Adults reporting unmet need** for MH treatment in 2018-2019: **6.1%**	• **Adults reporting unmet need** for MH treatment in 2018-2019: **7.5%**
Workforce	• Mental Healthcare Health Professional Shortage Areas (HPSAs) in 2023, **Percent of Need Met: 27.3%**	• Mental Healthcare Health Professional Shortage Areas (HPSAs) in 2023, **Percent of Need Met: 41.2%**	• Mental Healthcare Health Professional Shortage Areas (HPSAs) in 2023, **Percent of Need Met: 33.5%**	• Mental Healthcare Health Professional Shortage Areas (HPSAs) in 2023, **Percent of Need Met: 22.3%**	• Mental Healthcare Health Professional Shortage Areas (HPSAs) in 2023, **Percent of Need Met: 27.8%**

Table Note: In first two rows, lower numerical rankings indicate better performance and higher numerical rankings indicate worse performance for the metrics listed. The first two rows demonstrate Medicaid outcomes, while the last two rows refer to accessibility at large.[61,62,63,64,65,66,67,68,69,70] Pediatrics include ages 3 to 17.

[61] "10 Things to Know about Medicaid Managed Care | KFF," KFF, March 1, 2023, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

[62] "Medicaid State Fact Sheets | KFF," KFF, June 30, 2023, https://www.kff.org/interactive/medicaid-state-fact-sheets/.

[63] "Percent of Children (Ages 3-17) Who Received Any Treatment or Counseling from a Mental Health Professional | KFF," KFF, December 7, 2023, https://www.kff.org/mental-health/state-indicator/child-access-to-mental-health-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[64] "Share of Adults with Any Mental Illness in the Past Year Who Are Covered by Medicaid | KFF," KFF, July 21, 2022, https://www.kff.org/other/state-indicator/adults-with-any-mental-illness-in-the-past-year-with-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[65] "Individuals Reporting Needing but Not Receiving Treatment for Alcohol Use in the Past Year | KFF," KFF, January 24, 2023, https://www.kff.org/other/state-indicator/individuals-reporting-needing-but-not-receiving-treatment-for-alcohol-use-in-the-past-year/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[66] "Individuals Reporting Needing but Not Receiving Treatment for Illicit Drug Use in the Past Year | KFF," KFF, January 24, 2023, https://www.kff.org/other/state-indicator/individuals-reporting-needing-but-not-receiving-treatment-for-illicit-drug-use-in-the-past-year/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[67] "Access to Care Data 2022," Mental Health America, n.d., https://mhanational.org/issues/2022/mental-health-america-access-care-data#:~:text=The%20Access%20Ranking%20indicates%20how,special%20education%2C%20and%20workforce%20availability.

[68] "Adults Reporting Unmet Need for Mental Health Treatment in the Past Year | KFF," KFF, January 24, 2023, https://www.kff.org/other/state-indicator/adults-reporting-unmet-need-for-mental-health-treatment-in-the-past-year/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[69] "Adults with Mental Illness in Past Year Who Did Not Receive Treatment | KFF," KFF, March 10, 2021, https://www.kff.org/other/state-indicator/adults-with-mental-illness-in-past-year-who-did-not-receive-treatment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[70] "Mental Health Care Health Professional Shortage Areas (HPSAs) | KFF," KFF, November 6, 2023, https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Montana BH Service Needs - Key Findings

Collectively, the overview of Montana's geography, demographics, and prevalence of BH conditions across the State reinforces that Montana has notable challenges that must be addressed to improve BH outcomes across the State. Figure 29 offers a summary of the key findings related to Montana's characteristics that informed recommendations for improving behavioral healthcare in the State.

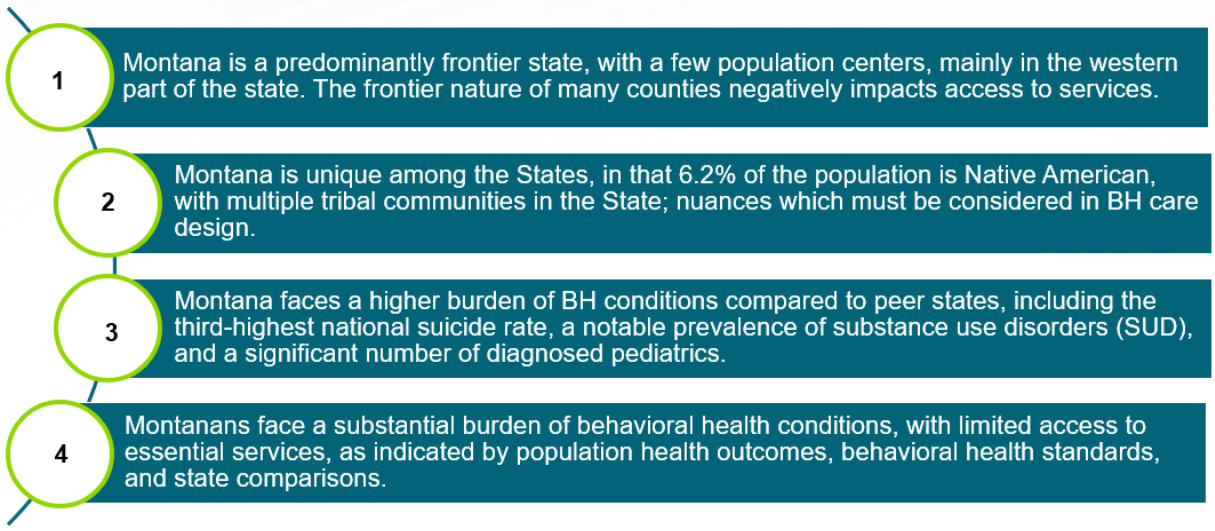


Figure 29. BH Service Needs – Key Findings

Access

To aid in assessing availability of behavioral healthcare access points, where behavioral healthcare can be received by Montanans, the study team grouped the behavioral healthcare sites into broad categories described in Table 14. These categories often leveraged SAMHSA's behavioral healthcare site definitions to have a similar basis of comparison with information and data published by SAMHSA on the nation and other states. Leveraging SAMHSA's definitions was also important in developing estimates of behavioral healthcare setting space needs in areas that lack access to care. A description of the various behavioral healthcare settings is seen in Table 14, ordered from highest acuity (IP) to lowest (community-based / routine care). One type of behavioral healthcare setting not included is I/DD care locations, which will be addressed in a separate, complementary study that will be issued to DPHHS and the BHSFG Commission.

BH is not limited to the nine care settings defined here. BH is also provided in locations such as schools and other community-based settings where individuals with BH conditions receive other services. Additionally, telehealth (telemedicine) is a key medium used in the process of providing behavioral healthcare from a distance via technology, such as videoconferencing. Telehealth can involve delivering care such as psychiatric evaluations, therapy (individual, group, and family therapy), patient education, and medication management. [71,72]

Of note, the CCBHC initiative, including provider transition to the CCBHC model, would promote a more integrated and comprehensive availability of OP BH services. Please refer to Recommendation 1.2 for further information on this future goal for Montana. This design study focuses on traditional behavioral healthcare settings as listed in Table 14.

[71] "What Is Telepsychiatry?," n.d., https://www.psychiatry.org/patients-families/telepsychiatry#:~:text=Telepsychiatry%2C%20a%20subset%20of%20telemedicine,patient%20education%20and%20medication%20management.

[72] Sara Abrams, "How Well Is Telepsychology Working?," *American Psychiatric Association* 51, no. 5 (July 1, 2020): 46, https://www.apa.org/monitor/2020/07/cover-telepsychology.

Table 14. Descriptions of Behavioral Healthcare Settings

No.	Category	Description[73,74,75,76]
1	**Inpatient (IP)**[77,78,79,80]	• **Psychiatric Hospital** – A licensed facility that provides individuals with BH conditions 24/7 supervised psychiatric care (including co-occurring diagnoses) along with ancillary supports. IP bed placement is reserved for clients with the highest level of need and is the most acute end of the BH treatment continuum. • **IP Psychiatric Unit** – An IP psych unit is a licensed psychiatric care unit embedded in a general hospital that provides IP psychiatric services in at least one separate psychiatric living unit. It has a similar scope of service and function as a psychiatric hospital. • **General Hospital** – An acute IP facility that can support BH needs of clients through assessment, evaluation, and coordination of next steps of behavioral healthcare. Depending on the hospital's resources and program design, evaluation of patients may be completed by a generalist or a BH specialist, in an ED.
2	**Crisis Services**	• **Fixed** - BH observation and stabilization services are provided in a home-like, non-hospital environment. Crisis stabilization facilities in Montana provide greater than 24 hours of crisis care, while Crisis receiving facilities provide less than 24 hours crisis care. Staffing is 24/7/365 and includes a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community. Staffing includes psychiatrists or psychiatric NP, nurse, other licensed and/or credentialed clinicians and peer specialists. Montana Medicaid policy requires 24/7 staffing of rehabilitation aides and 24/7 on call therapist(s). Office of Inspector General (OIG) licensing also requires 24/7 nursing. MH Centers operates these facilities thus a medical director is also required. • **Mobile** - Mobile crisis teams serve a similar function as fixed crisis services. They are available to reach, in a timely manner, any person in crisis at their home, workplace, or any other community-based location in their service area. They also connect individuals to facility-based care, as needed, through warm hand-offs and coordination of transportation. Staffing includes a licensed and/or credentialed clinician to conduct assessments.

[73] "Outpatient Mental Health Coverage," n.d., https://www.medicare.gov/coverage/mental-health-care-outpatient.

[74] "Behavioral Health Integration Fact Sheet," *American Psychological Association*, June 24, 2022, https://www.apa.org/health/behavioral-integration-fact-sheet.

[75] "Long-Term Care Facilities: Assisted Living, Nursing Homes, and Other Residential Care," National Institute on Aging, n.d., https://www.nia.nih.gov/health/assisted-living-and-nursing-homes/long-term-care-facilities-assisted-living-nursing-homes.

[76] Lauren B. Gerlach and Donovan T. Maust, "Falling off a Cliff: Psychiatric Care of Nursing Home Residents," *Journal of the American Geriatrics Society* 71, no. 4 (January 30, 2023): 1014–16, https://doi.org/10.1111/jgs.18249.

[77] "The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving toward Solutions," *American Psychiatric Association*, May 2022, https://www.psychiatry.org/getmedia/a73d03c3-f403-41fd-b59a-f8dcc4e204cb/APA-Psychiatric-Bed-Crisis-Report-Section-2.pdf.

[78] Sungkyu Lee, Aileen B. Rothbard, and Elizabeth Noll, "Length of Inpatient Stay of Persons with Serious Mental Illness: Effects of Hospital and Regional Characteristics," *Psychiatric Services* 63, no. 9 (September 1, 2012): 889–95, https://doi.org/10.1176/appi.ps.201100412.

[79] "Definitions of Inpatient and Outpatient Behavioral Health Services," *State of Massachusetts*, n.d., https://www.mass.gov/doc/appendix-b-bh-inpatient-and-outpatient-services-definitions-0/download.

[80] "The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving toward Solutions."

No.	Category	Description[73,74,75,76]
3	**Partial Hospitalization**[81]	Partial hospitalization provides a structured program of OP psychiatric services as an alternative to IP psychiatric care. A patient receives treatment during the day and does not stay overnight. Partial hospitalization programs are often offered by an IP care setting, such as a hospital. The daily program may be offered up to seven days in a week and include activities such as group therapy, educational sessions, skill building, individual therapy, and assessment. Partial hospitalization programs are utilized for SUD and MH treatments alike and may focus on special populations such as pediatric and older adults.
4	**Intensive Outpatient**[82,83]	Intensive outpatient programs (IOP) can be utilized to prevent IP hospitalization or as a step-down treatment for individuals for a variety of BH conditions who, post-discharge from IP care, are returning to their communities. IOP is often based out of an outpatient service center. Intensive outpatient programs are structured for a few hours a day, three to five days a week and can be considered a higher level of care to general OP services.
5	**Residential Facility**[84,85]	A residential treatment facility/program is designed to treat and support individuals with BH conditions whose symptom acuity is less than IP but still in need of residential treatment with the goal of community placement. It is a step down from IP with a different therapeutic focus. There are two main types of residential facilities - **Mental Health Residential** and **SUD Residential.** **Group Homes** are often considered a step down from residential facilities and align with a supportive, congregate living facility model. This type of residence provides additional care, supervision, and structure to residents with shared needs.
6	**OP Mental Healthcare (MHC)**[86,87]	A facility where MH services are provided to individuals in an ambulatory care setting. Outpatient MH services may include psychotherapy, medication management, case management, group therapy, peer support, and complementary and alternative medicine.
7	**OP SUD**[88,89]	Like OP MHC, OP SUD refers to a facility where services are provided to individuals with SUD in an ambulatory care setting. Outpatient SUD services include behavioral counseling and therapy, evaluation, and treatment of co-occurring disorders, such as anxiety and depression, substance use monitoring, case and clinical management, and medication-assisted treatment.

[81] "Partial Hospitalization Coverage," n.d., https://www.medicare.gov/coverage/mental-health-care-partial-hospitalization#:~:text=What%20it%20is,t%20have%20to%20stay%20overnight.

[82] Dennis McCarty et al., "Substance Abuse Intensive Outpatient Programs: Assessing the Evidence," *Psychiatric Services* 65, no. 6 (June 1, 2014): 718–26, https://doi.org/10.1176/appi.ps.201300249.

[83] Theodora Blanchfield, "How an Intensive Outpatient Program (IOP) Works," Verywell Mind, November 21, 2023, https://www.verywellmind.com/what-is-an-iop-intensive-outpatient-program-5521766.

[84] "Types of Treatment," April 24, 2023, https://www.samhsa.gov/find-support/learn-about-treatment/types-of-treatment.

[85] Michael Brodsky, "Residential Treatment — When to Consider It, What to Look For," *Social Work Today*, 2012.

[86] "Definitions of Inpatient and Outpatient Behavioral Health Services."

[87] "Mental Health Treatments," Mental Health America, n.d., https://mhanational.org/mental-health-treatments.

[88] "Definitions of Inpatient and Outpatient Behavioral Health Services."

[89] Cleveland Clinic Medical Professional, "Substance Use Disorder (SUD)," Cleveland Clinic, n.d., https://my.clevelandclinic.org/health/diseases/16652-drug-addiction-substance-use-disorder-sud.

No.	Category	Description[73,74,75,76]
8	**Integrated BH**[90,91,92]	An IBH center uses a care model that blends physical and behavioral healthcare, typically within a primary care setting. IBH centers accounted for in the data analysis only include Montana Healthcare Foundation IBH initiative grantees which have varying levels of implementation / adoption of IBH standards of care. PCPs in the program provide screenings for BH conditions, deliver immediate specialized behavioral healthcare, and/or facilitate warm hand-offs to BH providers.
9	**Multi-Setting**[93]	SAMHSA defines multi-setting as a facility that provides BH services in two or more service settings (non-hospital residential, plus either OP and/or day treatment/partial hospitalization), and are not classified as a psychiatric hospital, general hospital, medical center, or residential treatment center. Locating multiple service types at one location has become a strategy for BH facility design to improve client accessibility to services.

Understanding Montana's BH Service Delivery System

To understand Montana's current BH infrastructure, the study team worked to identify behavioral healthcare facilities across the State, categorized by type/care setting (see Table 15). The study team leveraged the following data from various sources, validated by DPHHS leadership, to analyze and map locations of behavioral healthcare settings.

- Medicaid claims data (IP, OP, and Professional Billing)
- Mental Health Group Homes (DPPHS list)
- Mental Health Centers
- Montana Mental Health Centers Youth Medicaid Services Guide
- Montana State Approved Substance Use Treatment Providers by County
- Medicare Compare (list of hospitals and nursing homes in Montana)
- Internet searches for Montana behavioral healthcare sites

The study team also mapped facility catchment areas around each care site. The catchment areas are based on assessment of reasonable drive times that considered frequency and urgency of patient visits associated with various level of behavioral healthcare (see Table 19).Table 15 identifies the variability in the distribution of BH facilities across regions, with Region 1 often showing the lowest number of behavioral healthcare settings by category and more populated regions having higher number of care settings. The analysis shows a discrepancy in access to behavioral healthcare settings for residents of very rural and frontier regions, such as Regions 1 and 2. This analysis demonstrates a significant lack of acute psychiatric care, crisis services, and partial hospitalization sites in Region 1.

[90] "Behavioral Health Integration Fact Sheet."

[91] "What Is Integrated Behavioral Health?," Agency for Healthcare Research and Quality, n.d., https://integrationacademy.ahrq.gov/about/integrated-behavioral-health.

[92] Montana Healthcare Foundation, "Integrated Behavioral Health - Montana Healthcare Foundation."

[93] "National Mental Health Services Survey 2020 (N-MHSS-2020-DS0001) | SAMHDA," n.d., https://www.datafiles.samhsa.gov/dataset/national-mental-health-services-survey-2020-n-mhss-2020-ds0001#:~:text=Multi-setting%20mental%20health%20facilities,center%2C%20or%20residential%20treatment%20center.

Table 15. Count of Locations that Provide BH Services/Care by Type and Region

Behavioral Healthcare Setting	Region 1	Region 2	Region 3	Region 4	Region 5	Statewide
Psychiatric Hospital	0	0	0	2	0	2
IP w/ Psychiatric Unit	0	1	1	1	2	5
IP (All)	12	14	13	16	15	70
Crisis Services	0	1	2	3	7	13
PHP	0	2	3	2	4	11
Intensive OP	4	10	12	15	13	54
Residential Facility	6	14	22	38	50	130
OP MHC	25	27	36	55	60	203
OP SUD	35	41	37	50	64	227
IBH	16	12	12	19	36	95
Multi-Setting	2	1	2	1	1	7

Lowest ***Highest***

Table Note: I/DD care sites are note included and will be examined in a separate study. Counts reflect number of behavioral healthcare locations' unique addresses (excluding suite numbers). That is, separate behavioral healthcare practices with the same address but different suite numbers are counted once in the table above. Count of behavioral healthcare site addresses that provide services listed above is current as of November 2023. Counts of "Psychiatric Hospital" and "IP w/ Psychiatric Unit" are included in "IP (All)." The list of IBH providers reflects a point-in-time, is self-reported, and only includes IBH facilities currently receiving funding from the Montana Healthcare Foundation.

Table 16. Distribution of Behavioral Healthcare Settings by Region[94]

Behavioral Healthcare Settings	Region 1	Region 2	Region 3	Region 4	Region 5	Montana
Psychiatric Hospital	0%	0%	0%	100%	0%	100%
IP w/ Psychiatric Unit	0%	20%	20%	20%	40%	100%
IP (All)	17%	20%	19%	23%	21%	100%
Crisis Services	0%	8%	15%	23%	54%	100%
PHP	0%	18%	27%	18%	36%	100%
Intensive OP	7%	19%	22%	28%	24%	100%
Residential Facility	5%	11%	17%	29%	38%	100%
OP MHC	12%	13%	18%	27%	30%	100%
OP SUD	15%	18%	16%	22%	28%	100%
IBH	17%	13%	13%	20%	38%	100%
Multi-Setting	29%	14%	29%	14%	14%	100%

Lowest ***Highest***

[94] Locations from DPHHS website (list of mental health agencies, Medicaid claims data, Medicare Compare (hospitals and nursing homes) Claritas (2023 Pop density).

Assessing Behavioral Healthcare Settings Access Relative to Population and Travel Distance

The distribution of care locations can be further contextualized relative to population size and drive time to better evaluate access to behavioral healthcare across the State. The two approaches are illustrated in Table 17 and Table 18, respectively, below. The study team compared the number of BH access points in each region relative to the region's total population to have a similar-sized comparison of access to behavioral healthcare settings by residents of each region. The analysis reinforced findings on the variability in distribution of BH access points/locations across regions. A further evaluation correlating BH access points relative to population, as seen in Table 17, shows that regions such as Regions 1 and 2 tend to have higher ratios of behavioral healthcare sites/population. However, counts of access points by regions only provided a partial view of the availability of care. It did not provide insight into capacity of each of the care sites (data which was not available). Access relative to distance helped to enhance knowledge of residents' relative access to care by showing that while residents in Regions 1 and 2 have higher ratios of care settings per population, their lower ratios relative to distance showed that Region 1 and 2 residents must travel farther for in-person or urgent behavioral healthcare compared to other regions (see Table 18). Additionally, Table 17 shows that Region 1 lacks partial hospitalization settings and has lower availability of residential care sites for its residents.[95]

Table 17. Behavioral Healthcare Settings per 100,000 Population by Region[96]

Behavioral Healthcare Settings	Region 1	Region 2	Region 3	Region 4	Region 5	Montana
Psychiatric Hospital	0.0	0.0	0.0	0.6	0.0	0.2
IP w/ Psychiatric Unit	0.0	0.7	0.4	0.3	0.6	0.5
IP (All)	15.7	9.2	5.7	5.2	4.4	6.3
Crisis Services	0.0	0.7	0.9	1.0	2.0	1.2
PHP	0.0	1.3	1.3	0.6	1.2	1.0
Intensive OP	5.2	6.6	5.3	4.8	3.8	4.9
Residential Facility	7.9	9.2	9.7	12.2	14.6	11.7
OP MHC	32.7	17.8	15.9	17.7	17.5	18.3
OP SUD	45.8	27.0	16.3	16.1	18.7	20.5
IBH	20.9	7.9	5.3	6.1	10.5	8.6
Multi-Setting	2.6	0.7	0.9	0.3	0.3	0.6

1st 2nd 3rd 4th 5th

[95] *Ibid*.

[96] Current inventory based on combination of SAMHSA National Directory Mental Health (MH) and Substance Use (SU) Facilities (2023), Medicaid claims data, DPHHS list of adult day care, adult foster care, hospitals, SUD, I/DD, long term care, mental health centers, residential facilities, youth group homes and shelters.

Table 18.Number of Behavioral Healthcare Settings in a 100 x 100 sq. mi. Grid (within a 2-hour drive)[97]

Behavioral Healthcare Settings	Region 1	Region 2	Region 3	Region 4	Region 5	Montana
Psychiatric Hospital	0.0	0.0	0.0	0.7	0.0	0.1
IP w/ Psychiatric Unit	0.0	0.3	0.4	0.4	1.0	0.3
IP (All)	2.8	4.8	5.1	5.6	7.8	4.8
Crisis Services	0.0	0.3	0.8	1.1	3.6	0.9
PHP	0.0	0.7	1.2	0.7	2.1	0.8
Intensive OP	0.9	3.4	4.7	5.3	6.7	3.7
Residential Facility	1.4	4.8	8.6	13.4	25.8	8.9
OP MHC	5.8	9.2	14.0	19.4	31.0	13.9
OP SUD	8.1	14.0	14.4	17.6	33.1	15.6
IBH	3.7	4.1	4.7	6.7	18.6	6.5
Multi-Setting	0.5	0.3	0.8	0.4	0.5	0.5

1st	2nd	3rd	4th	5th

Table Note: A site may be represented across multiple behavioral healthcare settings if it provides multiple services. There is wide variability in the capabilities of all the locations (unique addresses) in the inventory.

Assessing Medicaid Enrollee Access to Behavioral Healthcare – Map Visualization

While counts and relative distribution of behavioral healthcare settings by region are useful for a quantitative evaluation of the relative availability of behavioral healthcare settings across Montana's regions, it was also important, per study objectives, to plot the behavioral healthcare locations on a map of the State and its regions in order to have a visual/geographic perspective of the distribution and availability of BH services, the potential impact of service locations, and the challenges that some communities face in accessing BH services due to concentration of BH services in some communities in the regions.

The Alternative Settings design study primarily focused on the Medicaid population and state facilities that serve the needs of the BH population. As such, the following maps focus on care sites that primarily serve the Medicaid population. Medicaid enrollees' access to behavioral healthcare settings was evaluated based on review of claims data, indication on behavioral healthcare settings lists/rosters provided by DPHHS of care sites that indicated acceptance of Medicaid clients/patients, as well as DPHHS staff review. Sites of care that did not indicate acceptance of Medicaid and were not included in recent Medicaid BH population claims data were not flagged as Medicaid accepting behavioral healthcare sites.

Each map of behavioral healthcare settings shows Medicaid accepting locations with drive-time catchment areas depicted around them. Optimal drive time per behavioral healthcare setting, along with a rationale articulating how the study team assigned what would be classified as "optimal" is shared in Table 19. The study team acknowledges there is an inherent degree of subjectivity in setting an "optimal drive-time" standard.

[97] *Ibid.*

Table 19. Drive-time Catchment Areas for Behavioral Healthcare Settings

Behavioral Healthcare Settings	Optimal Drive-Time	Rationale
IP Psychiatry Beds	120 minutes	IP psychiatric placements are overnight, of intentional length, and require specialist oversight.
Crisis Services (Fixed) *Study team use rate estimates: 60 minutes	60 minutes, population centers* 120 minutes, frontier communities	SAMHSA standards for crisis programs adhere to 1-hour response time, with a 2-hour exception for frontier or rural communities.
Crisis Services (Mobile) *Study team use rate estimates: 60 minutes	60 minutes, population centers* 120 minutes, frontier communities	SAMHSA standards for crisis programs adhere to 1-hour response time, with a 2-hour exception for frontier or rural communities.
Partial Hospitalization Program (PHP)	60 minutes	Partial hospitalization programs require clients to travel to a care site every day, often five or more days a week, and return to their home each evening.
Intensive Outpatient Program (IOP)	60 minutes	Like PHPs, IOPs require clients to visit a care site multiple times a week (typically three days) and return home at the end of sessions.
SUD Residential	90 Minutes	SUD Residential programs require clients to stay overnight for a set period. Programs may involve engagement with client family members, increasing travel.
MH Residential	90 minutes	MH Residential programs require clients to stay overnight for a set period. Programs may involve engagement with client family members, increasing travel.
Group Homes	90 minutes	Group homes involve full-time, overnight client placement, but often can involve a longer length of stay.
Multi-Setting Facilities	60 minutes	Multi-setting facilities often involve both OP, IP, and ancillary services, making their optimal accessibility moderate.

Figure 30 shows all types of **Behavioral Healthcare Settings that Accept Medicaid.** Figure 30 is a high-level visual of all behavioral healthcare setting types. Behavioral healthcare sites are found in zip codes where large Medicaid enrollee populations are (darker blue shading). High Medicaid population areas are correlated with areas with higher total population. Due to limitations in data available, the study team was not able to assess the range of services, capacity, and volume of services provided at each care site. To provide insight into access to services in each region, the next series of maps show the distribution of each behavioral healthcare setting type across the state, highlighting where there are gaps in access to specific types of BH services for Medicaid enrollees.

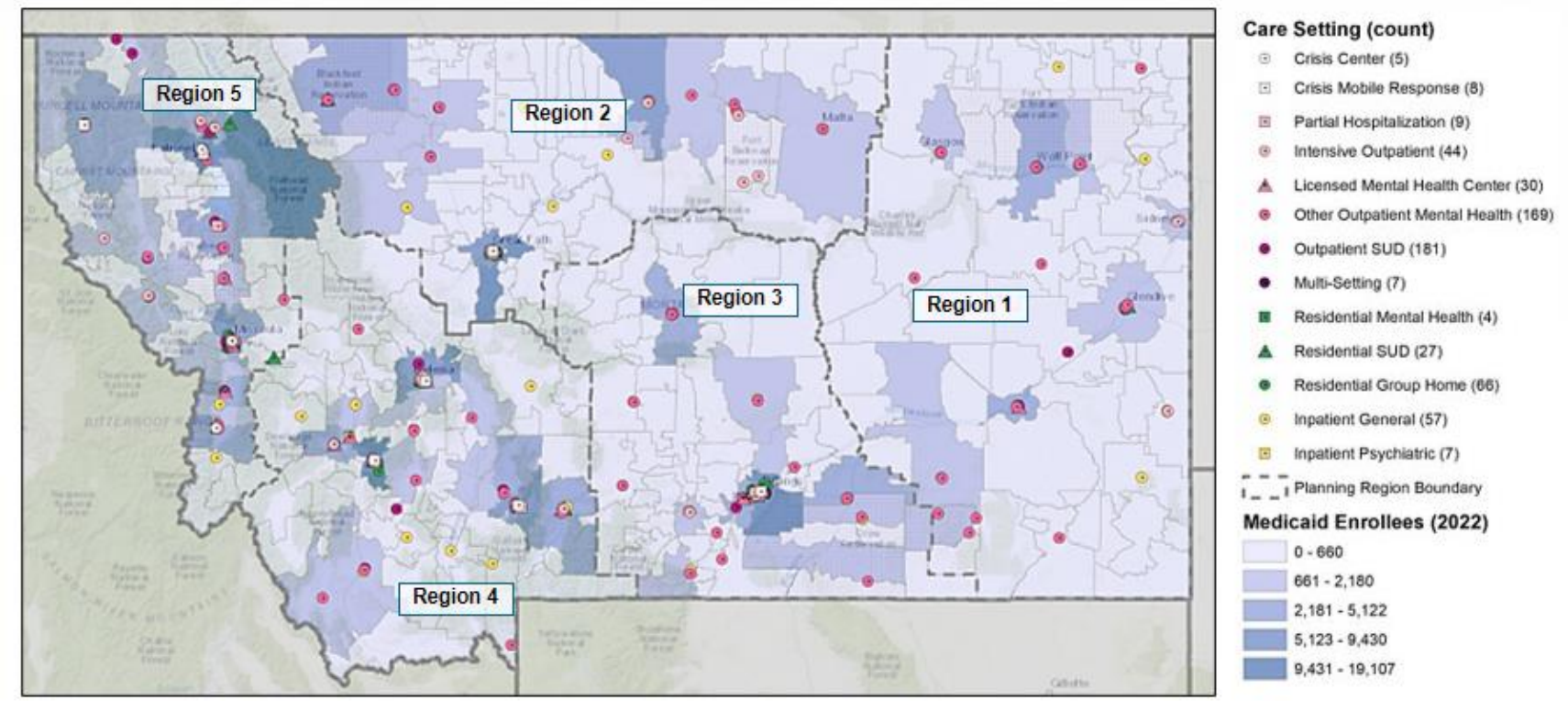


Figure 30. Behavioral Healthcare Settings that Accept Medicaid

Figure Note: The **behavioral healthcare settings shown on this map, as well as succeeding maps, is current as of November 2023**. Closures or additions since that time are not reflected.

Figure 31 shows **IP General Hospitals that Accept Medicaid.** IP hospitals are well-distributed across the State. These locations are part of the behavioral healthcare continuum as these sites include an ED, where individuals with BH conditions often seek care, especially when dealing with a BH crisis or life-threatening situation. However, not all general hospitals are equally equipped to adequately serve the needs of the BH population. There is wide variability in the scope of BH services and workforce available at each of these sites.

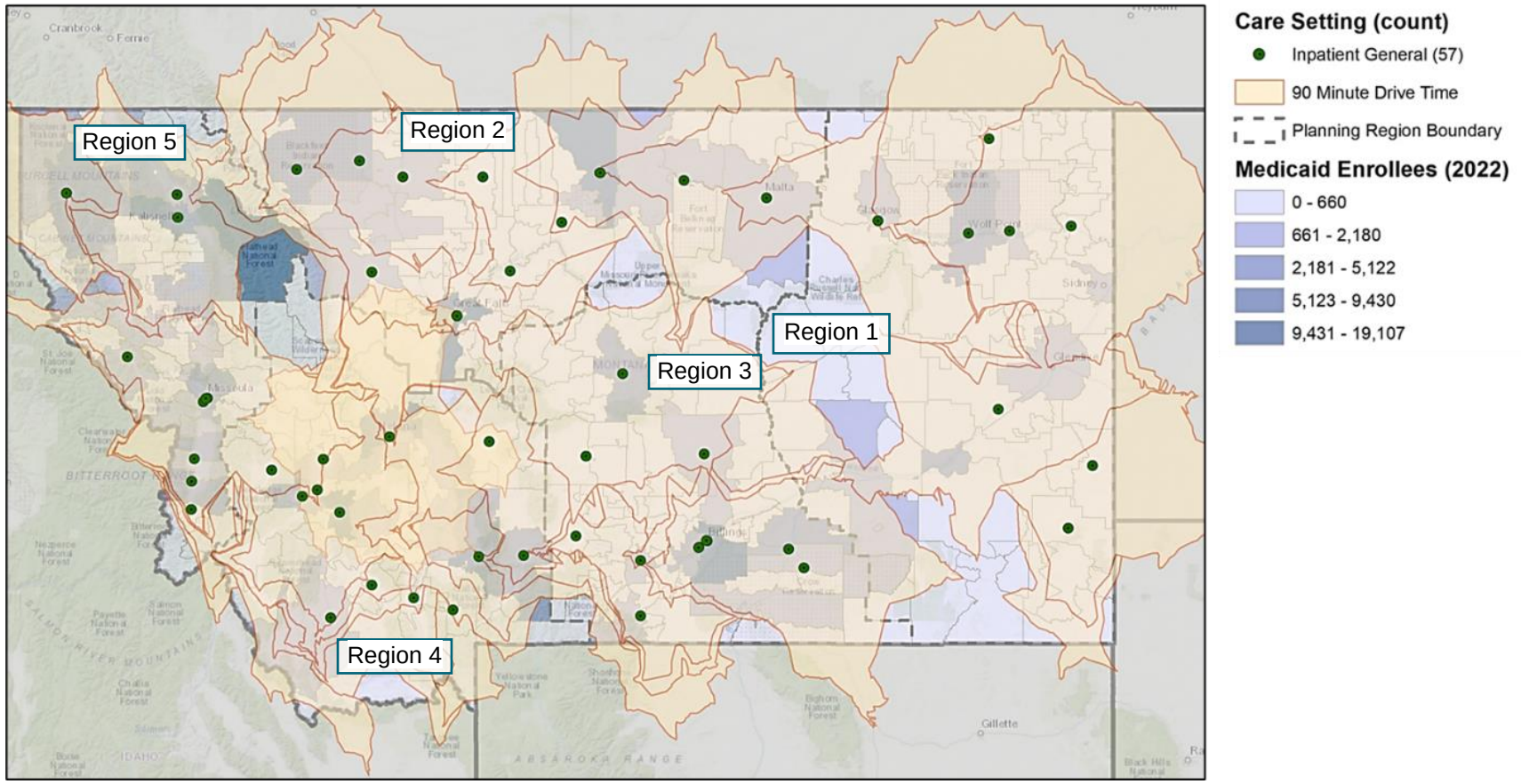


Figure 31. IP General Hospitals that Accept Medicaid

Figure Note: The map reflects data as of November 2023.

Figure 32 shows **IP Psychiatric Care Sites (Psychiatric Hospitals + Psychiatric Units) that Accept Medicaid.** While existing coverage is correlated with major Medicaid enrollee and population centers, IP psychiatric care is limited in the eastern part of the State, especially in Regions 1 and 2.

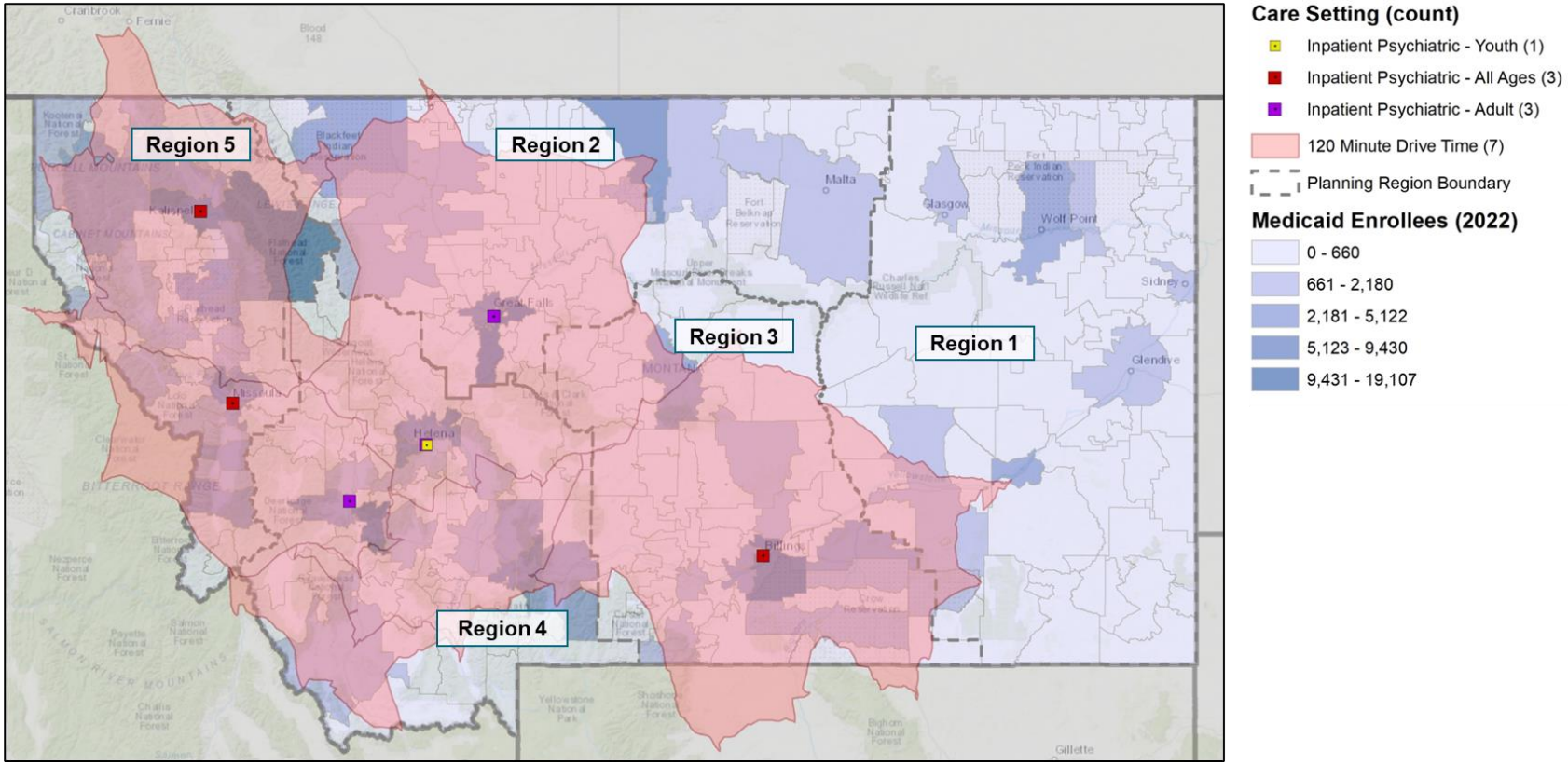


Figure 32. IP Psychiatric Care Sites that Accept Medicaid

Figure Note: The map reflects data as of November 2023. Sites include Psychiatric Hospitals and Psychiatric Units.

Figure 33 shows **MH Residential Care Sites that Accept Medicaid.** Large swaths of the State do not have access to MH residential care that accepts Medicaid enrollees. MH residential care sites are further specialized by PRTFs and sites that offer crisis services. Evaluated at the specialty level, the lack of access to MH residential services is even more pronounced due to the care sites serve a sub-set of the population.

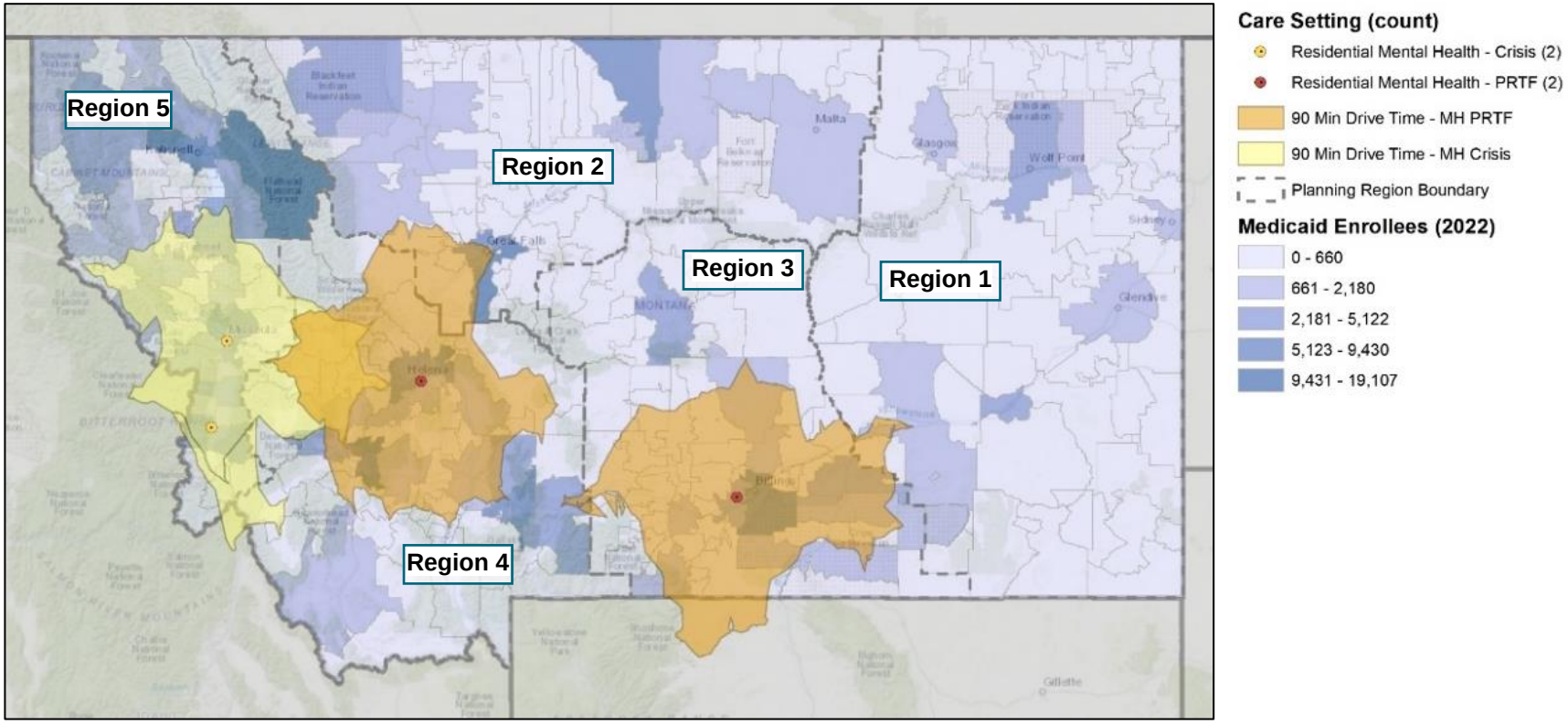


Figure 33. MH Residential Care Sites that Accept Medicaid

Figure Note: The map reflects data as of November 2023.

Figure 34 shows **SUD Residential Care Sites that Accept Medicaid.** Large areas of the State lack access to SUD residential care for Medicaid enrollees, especially in the eastern and north/central regions.

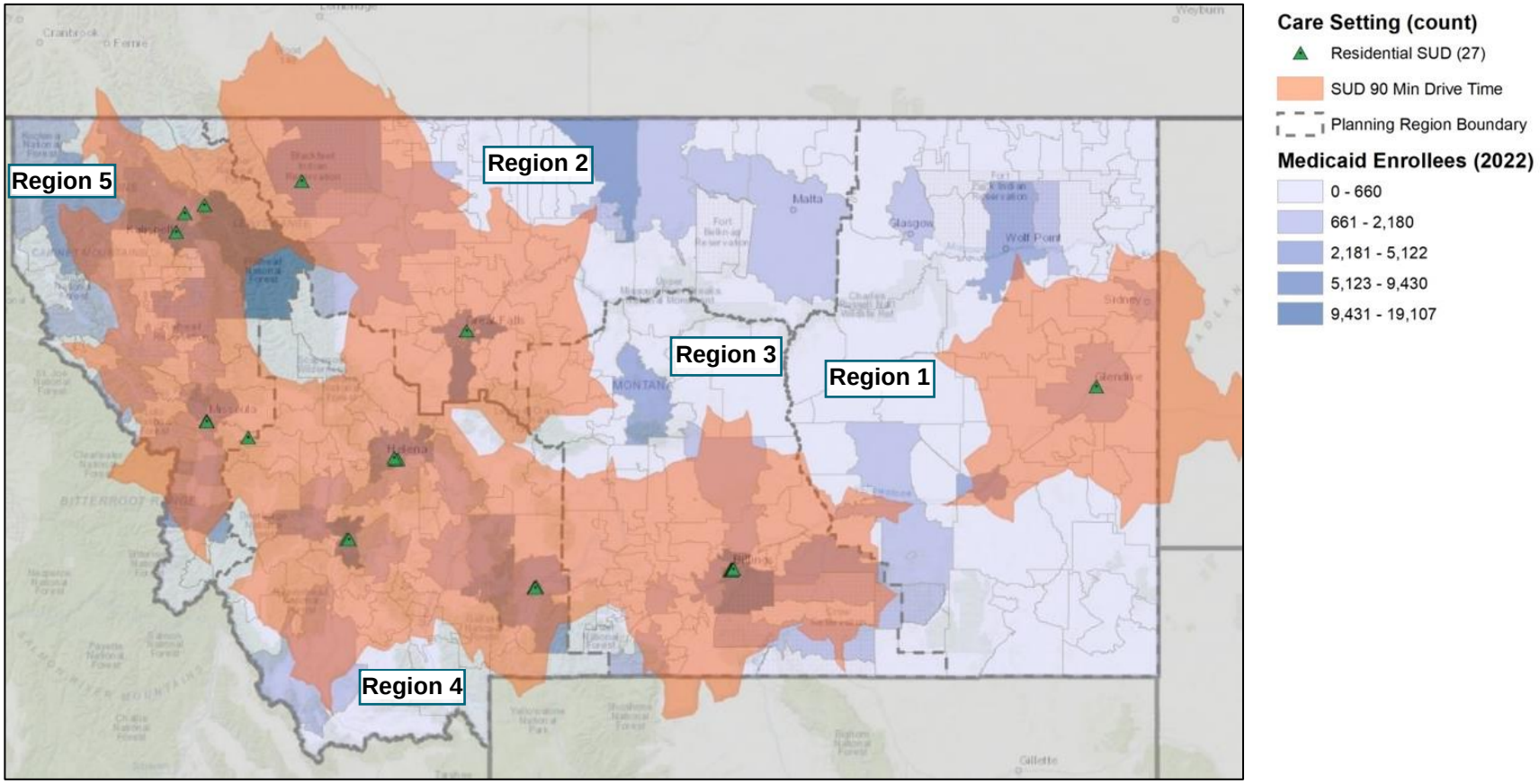


Figure 34. SUD Residential Care Sites that Accept Medicaid

Figure Note: The map reflects data as of November 2023. SUD ASAM 3.5 Residential settings in Clinton, MT or the ASAM 3.1 setting in Kalispell, MT appear on this map but are no longer active.

Figure 35 shows **Group Home Residential Care Sites that Accept Medicaid.** Although group homes that accept Medicaid enrollees are more readily available, there are still substantial portions of the State that do not have group home coverage, especially in the north/central part of the State.

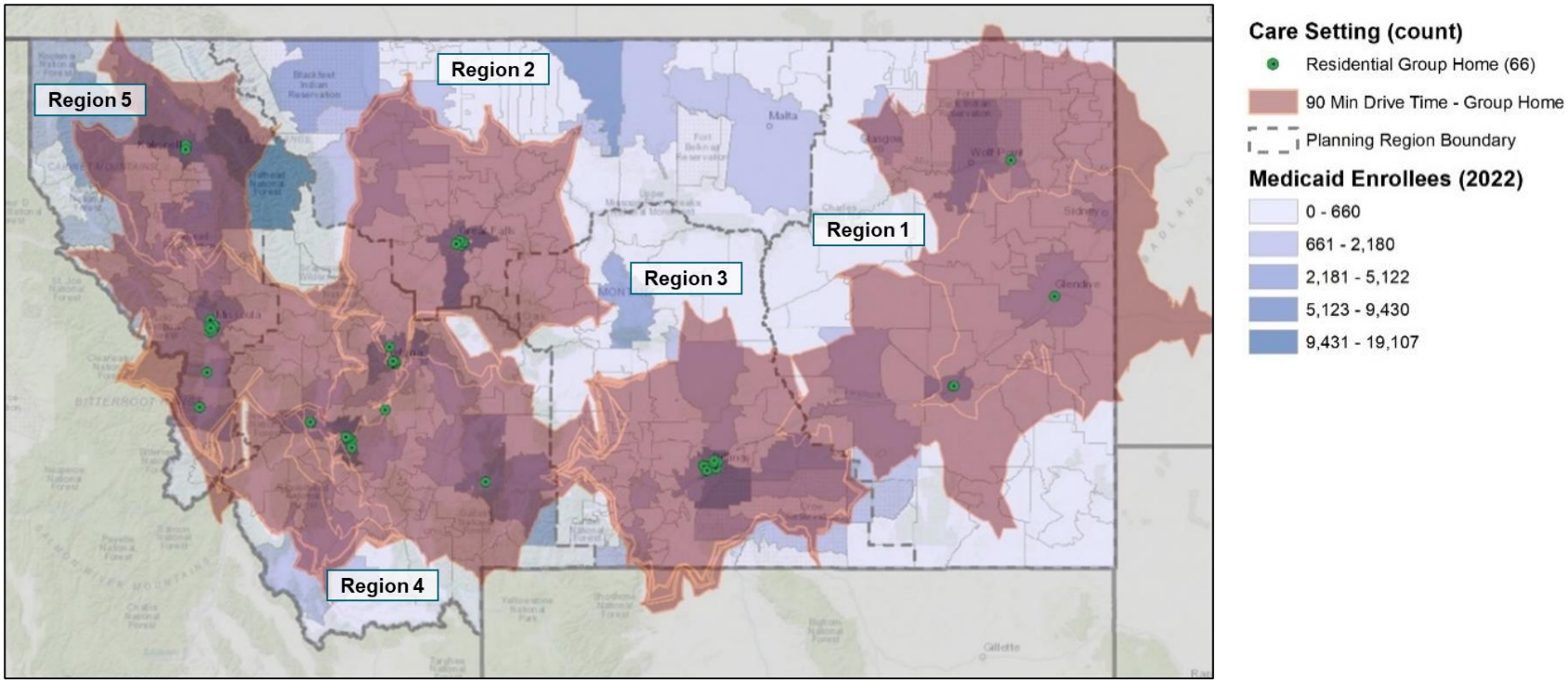


Figure 35. Group Home Residential Care Sites that Accept Medicaid

Figure Note: The map reflects data current as of November 2023. Group home availability is based on known data and is subject to change particularly based on Residential Grant Near Term Initiative (NTI) funding intended to reopen closed group homes.[98]

[98] "DPHHS Launches Grant Program to Increase Residential Bed Capacity," n.d., https://dphhs.mt.gov/News/2024/February/GrantProgram.

Figure 36 shows **Partial hospitalization (PHP) & Intensive Outpatient Programs (IOP) that Accept Medicaid.** PHP and IOP care sites are in areas where there are sizable populations of Medicaid enrollees. However, there are still substantial portions of the State with high Medicaid populations (darker blue) which do not have access to PHP and IOP services. Residents in these areas are burdened with longer drive times and geographic challenges to get PHP or IOP care, care which often requires multiple visits in a week for many months. This is especially challenging for residents in the eastern, central, and part of the northwestern area of the State.

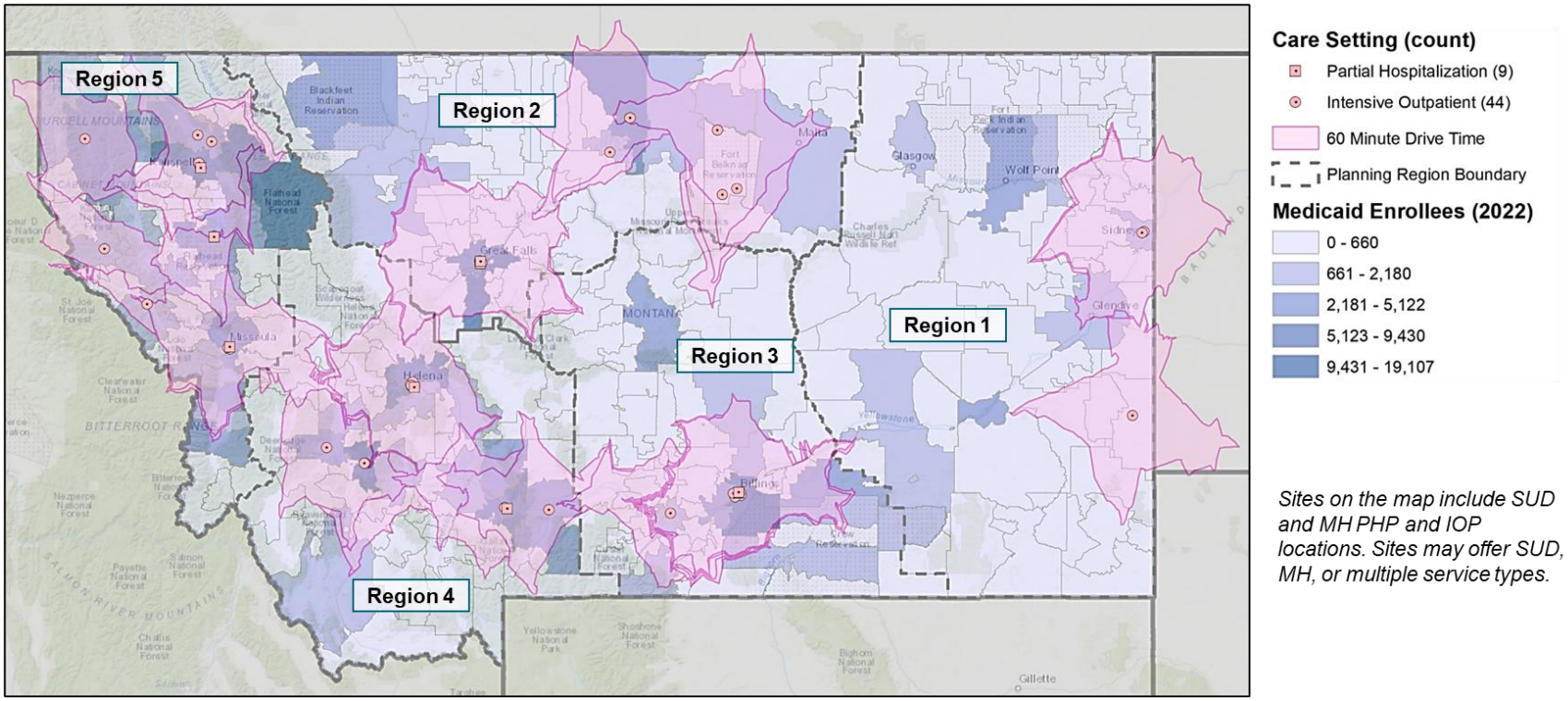


Figure 36. Partial Hospitalization & Intensive OP Programs that Accept Medicaid

Figure Note: The map reflects data as of November 2023. IOP locations include function specific sites such as substance use IOP, pediatric MH IOP, adult MH IOP, pediatric MH IOP, adult MH IOP, which includes day treatment, PAC, Montana Assertive Community Treatment, and other.

Figure 37 shows **Crisis Stabilization Programs in Montana.** Crisis care settings are in more densely populated areas in the western portion of the State. Crisis stabilization and mobile crisis team sites only cover a small portion of the State. The regions most affected by a lack of access to crisis care are Regions 1, 2, and 3. Notably, all regions in the State have communities that lack ready access to this specialized behavioral healthcare setting and service.

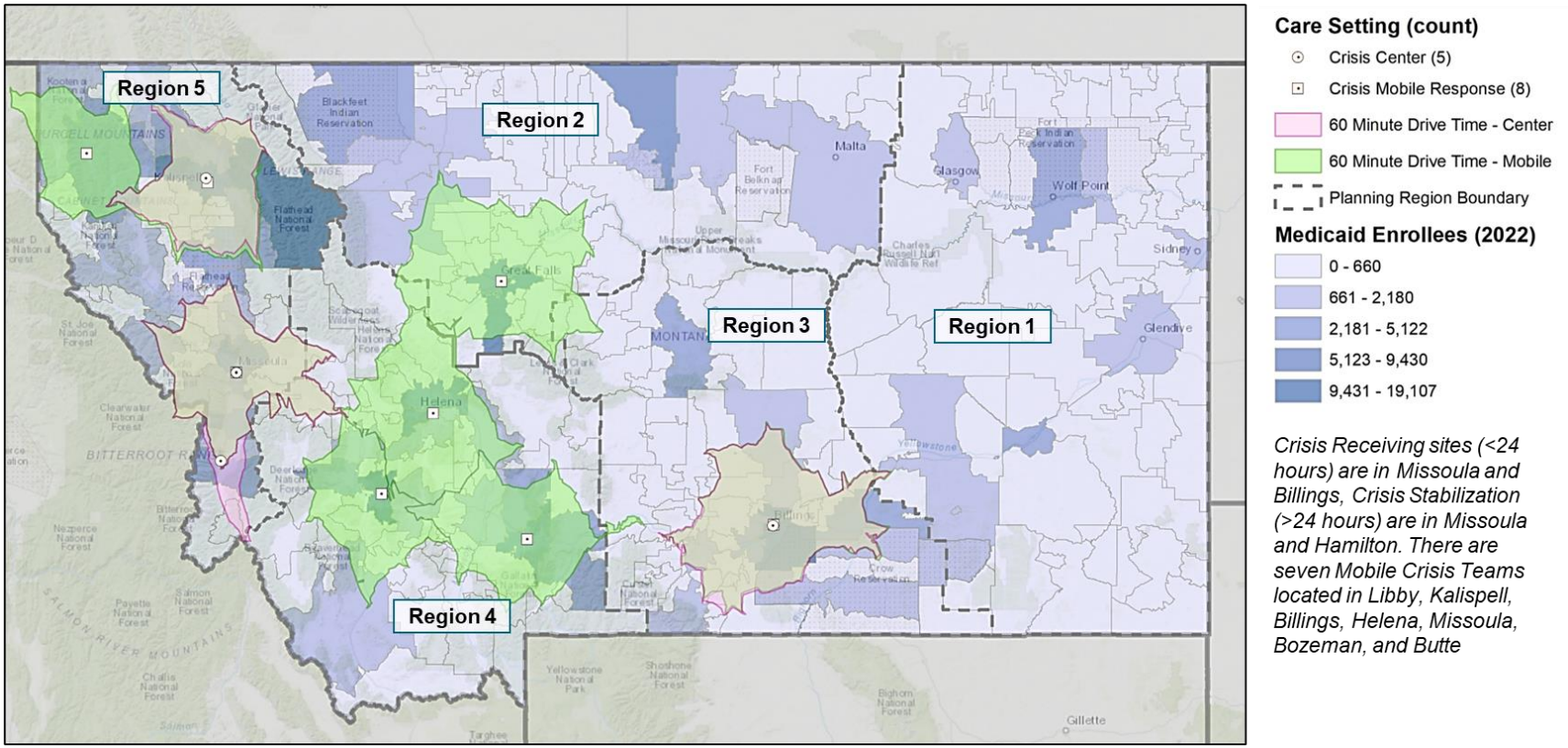


Figure 37. Crisis Stabilization Programs in Montana

Figure Note: The map reflects data as of November 2023.

Figure 38 shows **MH Outpatient Sites that Accept Medicaid.** MH OP sites are more evenly distributed across the State than other behavioral healthcare settings, but long drive times for routine services pose limits to convenient access.

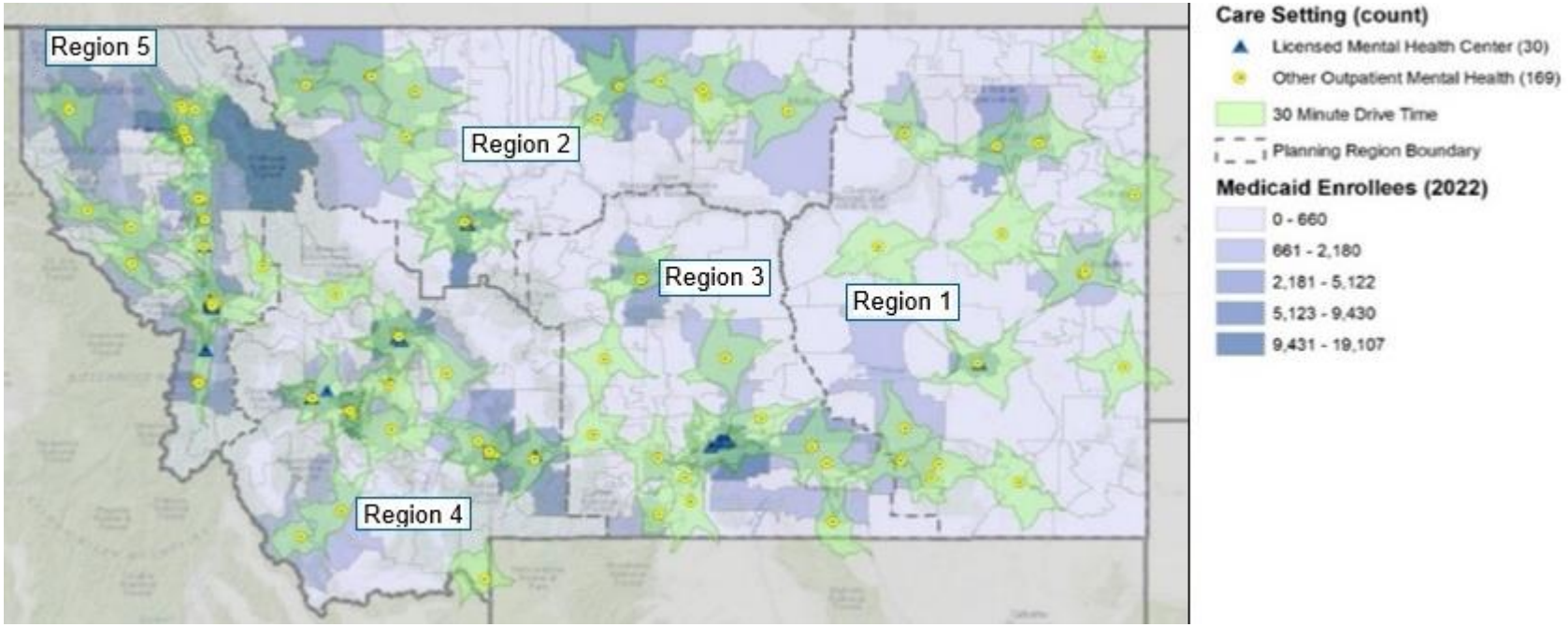


Figure 38. MH Outpatient Sites that Accept Medicaid

Figure Note: The map reflects data as of November 2023. Sites identified by blue triangles are the main offices of licensed Mental Health Centers. "Other Outpatient Mental Health" sites are MH Center Satellite offices.

Figure 39 shows **IBH Sites that Accept Medicaid.** Most IBH sites are in more densely populated areas. Sites located in rural/frontier areas could help bridge the gaps in BH service and treatment access.

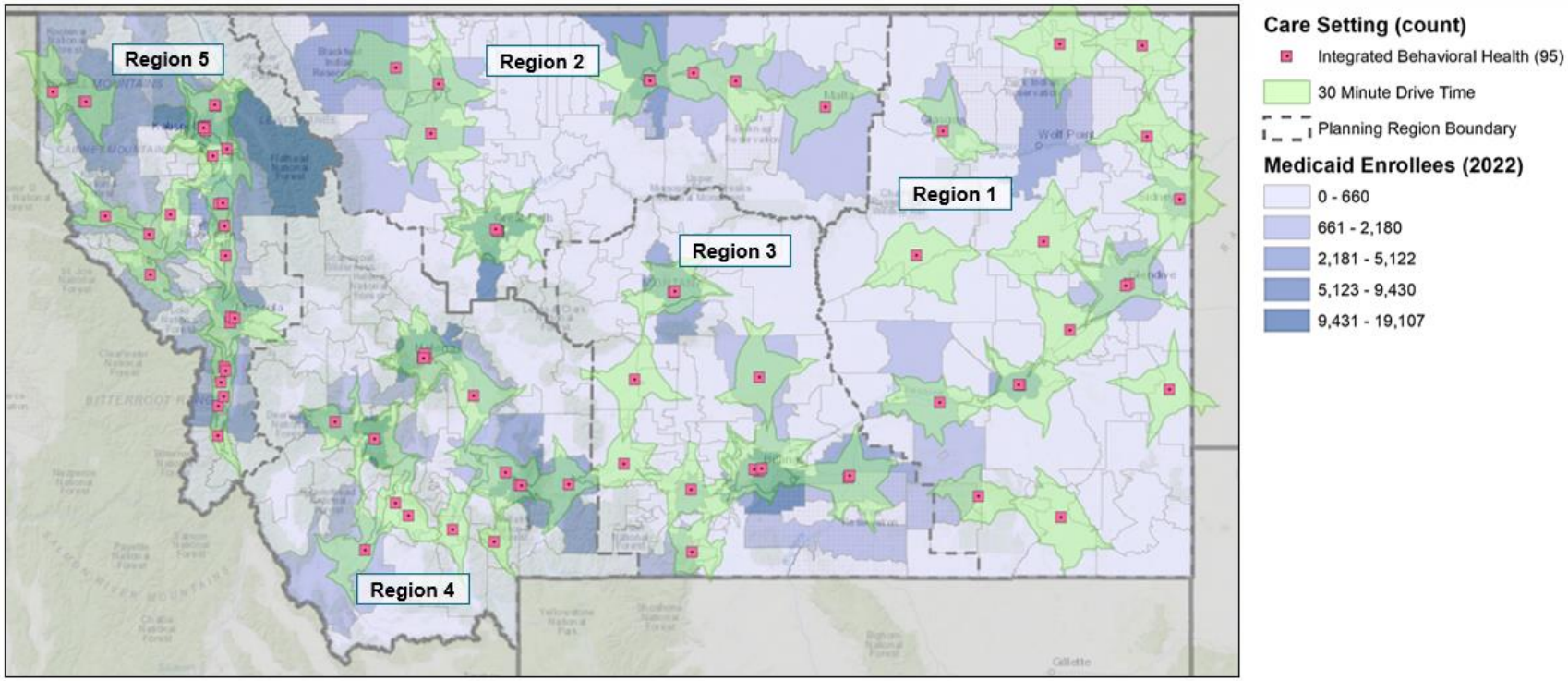


Figure 39. IBH Sites that Accept Medicaid

Figure Note: The map reflects data as of November 2023.

Figure 40 shows **SUD Outpatient Sites that Accept Medicaid.** Like MH OP sites, SUD OP sites are more evenly distributed across the State than other behavioral healthcare settings, but Medicaid enrollees and others seeking BH in many communities throughout the State must travel farther than ideal distances to access this type of care.

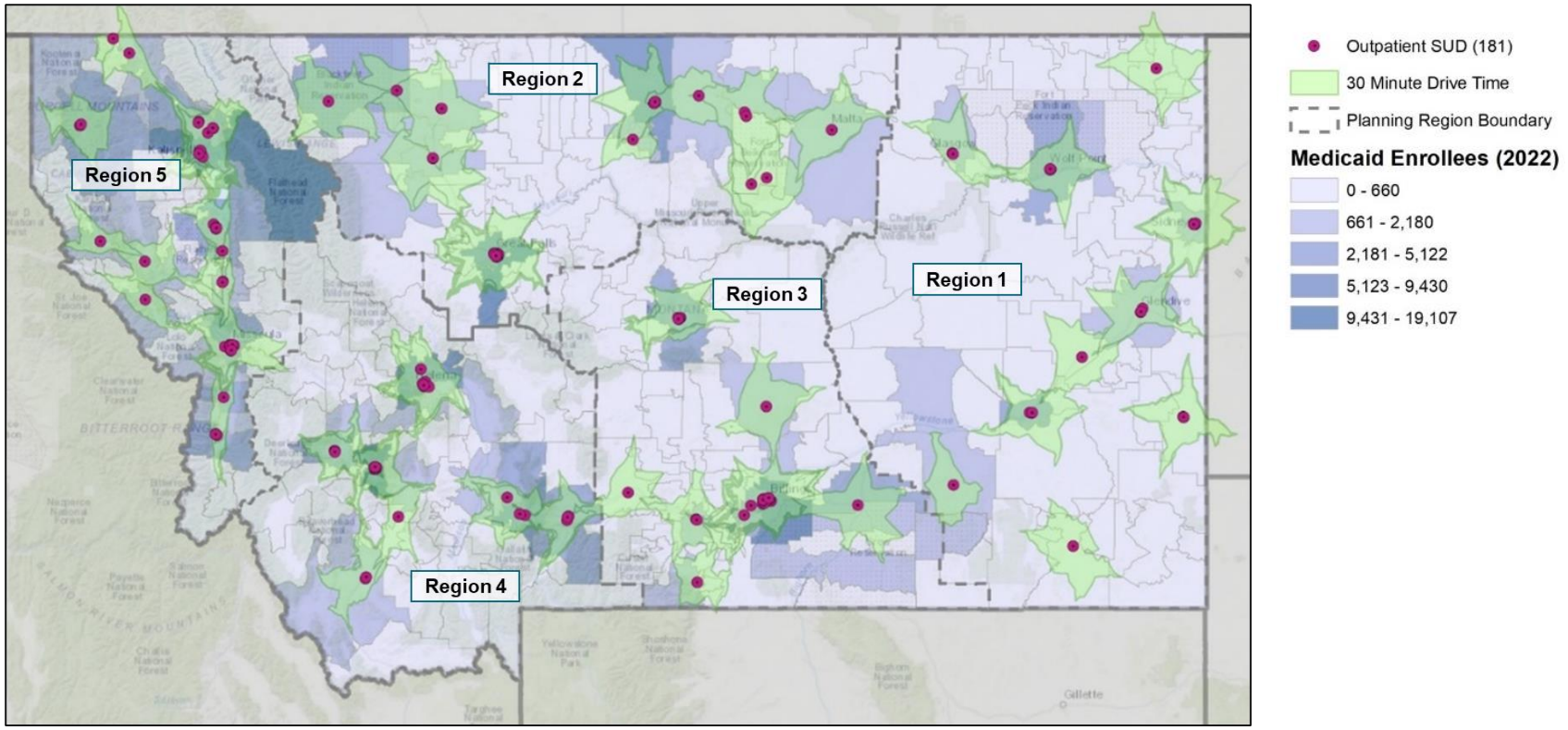


Figure 40. SUD Outpatient Sites that Accept Medicaid

Figure Note: The map reflects data as of November 2023.

Figure 41 shows **Multi-Setting Care Sites that Accept Medicaid.** Large parts of the State do not have multi-setting care sites. Care sites that offer multiple BH services in one location are widely seen as a promising practice for future-state network planning, as reinforced by feedback during multiple Subcommittee meetings.

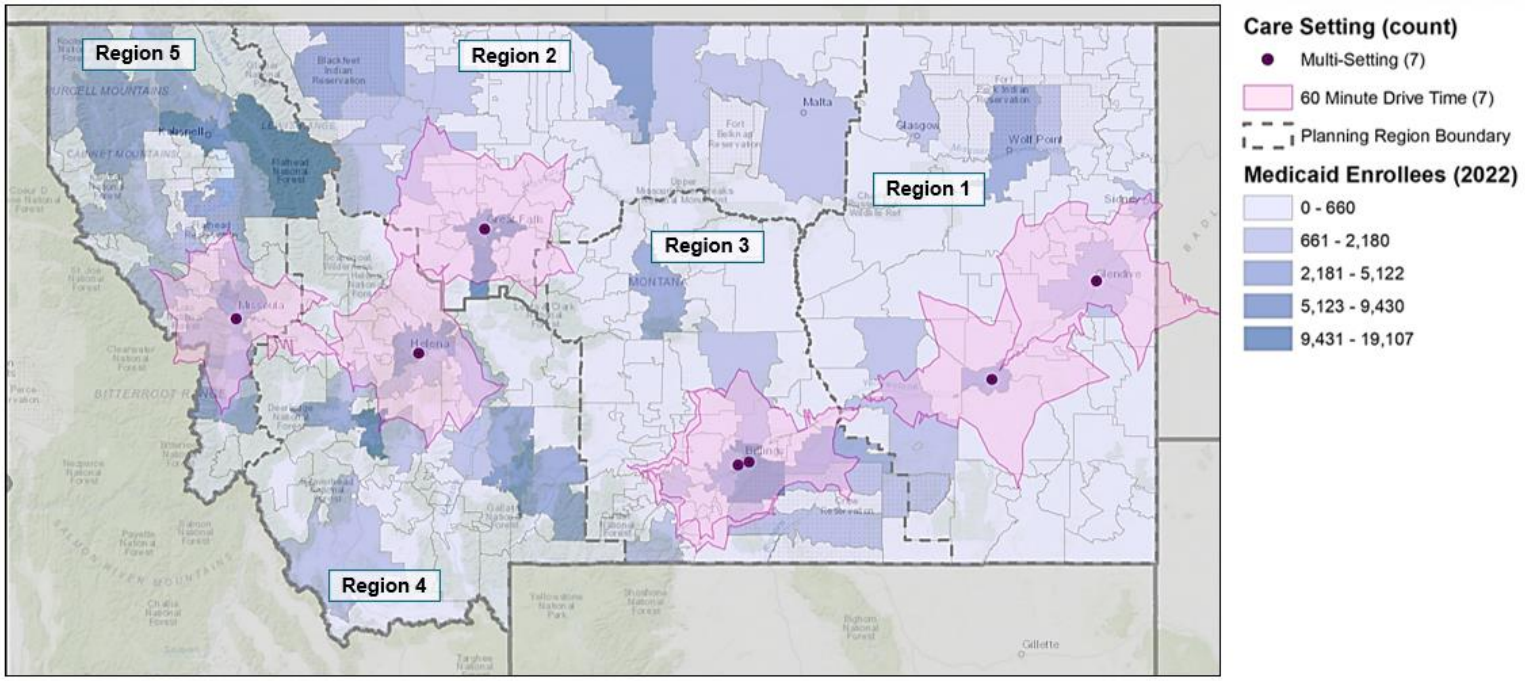


Figure 41. Multi-Setting Care Sites that Accept Medicaid

Figure Note: Multi-setting care sties is defined as "facilities providing mental health services in two or more service settings (non-hospital residential, plus either outpatient and/or day treatment/partial hospitalization), and are not classified as a psychiatric hospital, general hospital, medical center, or residential treatment center." [99] The map reflects data as of November 2023.

[99] Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey (N-MHSS): 2019. Data on Mental Health Treatment Facilities.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020. https://www.samhsa.gov/data/sites/default/files/reports/rpt29388/2019_NMHSS/2019_NMHSS.html

Other Analyses Illustrating Behavioral Healthcare Access and Care Gaps in Montana

The study team completed various analyses to help quantify the access challenges that residents of Montana face in getting needed BH services. The analyses in this section provide insight into the rationale behind the analyses and highlight key observations that informed the study recommendation.

Montana Behavioral Healthcare Setting Distribution Versus Peer/Comparison States

Our analysis measured the number of behavioral healthcare settings relative to the population in each state for an apples-to-apples perspective. The study team used two general approaches to assess the differences in access to behavioral healthcare across various states:

- Comparison of the availability of behavioral healthcare sites for various states agencies from SAMHSA's directory of MH and SUD sites.
- Comparison of BH clients and facilities based on data from SAMHSA's N-MHSS (2018) and N-SSAT (2019) survey reports showing point-in-time snapshots of behavioral healthcare facility utilization across the nation and for states.

The two analytical approaches resulted in the following key findings:

- While Montana has more behavioral healthcare settings than a few comparison states, it lacks adequate BH workforce to support the care settings and readily meet the needs of residents in its communities, which may be an underlying factor for Montana's lower BH ranking than many other states.
- There are other BH ecosystem and care continuum factors that also impact Montana's lower rankings that must also be taken into consideration to design a more effective BH ecosystem.

To facilitate a focused and comprehensive assessment of access to behavioral healthcare in Montana and other comparison states, the study team narrowed the number of comparison states to North Dakota, South Dakota, and Wisconsin. North Dakota and South Dakota were selected because they are like Montana in geography and population demographics and are neighboring states. Wisconsin was included and confirmed as a reasonable comparison state by DPHHS as it is a top ranked state for BH outcomes and has sufficient rurality to influence how BH ecosystem must function. Other top ranked states are less comparable to Montana because they have majority high-density population areas and lower proportions of Tribal population.

In the absence of readily available and comprehensive data detailing total behavioral healthcare settings available in various states, the study team leveraged SAMHSA's directory of state MH and SUD agencies to provide a representative sample of behavioral healthcare settings. This allowed the study team to compare access to behavioral healthcare sites across peer states. The analyses, seen in Table 20 and Table 21, show that Montana often has a higher ratio of behavioral healthcare settings per capita than comparison states that have higher BH rankings than Montana. For example, Montana has higher ratios of behavioral healthcare settings per capita than Washington, Wisconsin, Massachusetts, and Iowa, but has lower overall BH rankings than these states. However, average number of care settings per capita did not provide a holistic understanding of access to care in Montana versus other states. Additional analyses, covered in the rest of this section, were required to gain a more robust understanding of the root causes of Montana's BH ecosystem challenges.

Table 20. State BH Agencies per 100,000 Population (2023) [100,101,102]

Behavioral Healthcare Settings	MT	ND	SD	WA	WI	MA	WY	IA
IP	0.9	1.0	1.5	0.5	1.0	0.9	1.6	0.8
Partial Hospitalization	1.1	2.5	0.6	0.5	0.7	1.0	1.0	0.8
Residential	2.8	3.2	2.4	1.0	0.6	1.9	3.3	1.4
OP SUD	10.5	7.0	6.4	5.5	4.4	5.0	8.1	6.0
OP MHC	2.7	1.9	2.4	2.4	2.8	1.7	4.3	2.0
Intensive OP	4.0	3.6	3.0	3.1	1.1	1.1	5.2	2.9
Multi-Setting	0.6	0.3	0.0	0.1	0.1	0.1	0.3	0.0

Table Note: Data is from SAMHSA's report detailing number of State Mental Health agencies in each state. The study team leveraged data from SAMHSA's directory of State MH and SUD agencies to use as a representative sample to compare availability of behavioral healthcare settings in Montana versus peer and comparison states. The table shows average number of behavioral healthcare setting types per 100,000 persons who live in these states, color coded from highest (green) to lowest value (red). It shows the comparison of availability of State Mental Health Agencies relative to population across the care setting types for the states displayed. Site counts are based on count of unique addresses in SAMHSA's database. A site may be represented across multiple care settings if it offers relevant services for the category. Other care settings are not shown due to lack of data.

Table 21. Mental Health America BH State Rankings[103]

Select BH Rankings	MT	ND	SD	WA	WI	MA	WY	IA
2023 Overall Rank	31	21	37	32	1	3	45	20

Table Note: 2023 overall rank is from Mental Health America, which used an evaluation methodology that incorporates prevalence of BH conditions, access to BH care, and BH workforce availability factors.

Beyond analyzing the number of behavioral healthcare sites per capita, the study team provided a more holistic perspective of access to care by calculating the average BH workforce available per care setting for each of the comparison states. This aided the study team in gaining a better understand of the capacity of the average care site in each state to provide readily available and effective care to their residents.

Table 22 shows that Montana's reported challenges with access to care, despite having more care sites on average than other comparison states, may be related to a limited BH workforce, which negatively impacts capacity to care for residents of Montana. The analysis shows that the average number of specialists available to serve residents across Montana's care settings is lower, for every care setting, than top ranked Wisconsin and often lower than neighboring state, North Dakota, which is ranked 21st while Montana is ranked 31st.

[100] "Behavioral Health Workforce Tracker," Data set, *Fitzhugh Mullan Institute for Health Workforce Equity*, n.d., https://www.gwhwi.org/behavioralhealth-workforce-tracker-v20.html.

[101] "National Directory of Mental Health Treatment Facilities 2021," *Substance Abuse and Mental Health Services Administration (SAMHSA)* (SAMHSA, April 2021), https://www.samhsa.gov/data/sites/default/files/reports/rpt34657/National_Directory_MH_facilities_2021.pdf.

[102] "National Directory of Drug and Alcohol Abuse Treatment Facilities 2022," *Substance Abuse and Mental Health Services Administration (SAMHSA)* (SAMHSA, April 2022), https://www.samhsa.gov/data/sites/default/files/reports/rpt35993/SA%20facilites/SU%20Directory/National_Directory_SA_facilities_final_04272022.pdf

[103] List of State Mental Health Agencies from SAMHSA National Directory of Mental Health (MH) and Substance Use (SU) Facilities (2023), Claritas (2023 demographics), https://www.mhanational.org/issues/2023/ranking-states

In contrast, comparing Montana to South Dakota, Table 23 shows that Montana has higher average number of psychologists per location than South Dakota. Montana is ranked higher than South Dakota in behavioral healthcare, overall (see Table 21). The analysis findings indicate that there is a correlation between a sufficient workforce to support behavioral healthcare settings and higher BH rankings and care outcomes. Without adequate workforce support, activating new care sites to address a service setting gap would be ineffective.

Table 22. Average Psychiatric Provider Per Location (2023)[104,105,106,107]

Behavioral Healthcare Settings	MT	ND	SD	WI
IP	10.1	15.7	8.3	14.5
Partial Hospitalization	8.3	6.3	20.7	20.7
Residential	3.3	4.9	5.2	24.2
OP SUD	0.9	2.2	1.9	3.3
OP MHC	3.4	8.3	5.2	5.2
Intensive OP	2.3	4.4	4.1	13.2
Multi-Setting	15.2	52.5		145.2

Table Note: Site counts are based on number of unique addresses. A site may be represented across multiple care settings if it offers relevant services for the care setting category. Blank cells represent that no data was available.

Table 23. Average Psychologist Per Location (2023) [108,109,110]

Behavioral Healthcare Settings	MT	ND	SD	WI
IP	29.4	34.5	12.5	34.2
Partial Hospitalization	24.1	13.8	31.2	48.8
Residential	9.4	10.8	7.8	57.0
OP SUD	2.5	4.9	2.9	7.8
OP MHC	9.8	18.2	7.8	12.2
Intensive OP	6.6	9.6	6.2	31.1
Multi-Setting	44.1	115.1		341.9

Table Note: Site counts are based on number of unique addresses. A site may be represented across multiple care settings if it offers relevant services for the care setting category. Blank cells represent that no data was available.

[104] Definitive Healthcare list of BH providers in Montana, providers listed in the Medicaid MMIS claims data set (2018-2023). Locations are from Substance Abuse and Mental Health Services Administration (SAMHSA) National Directory of Mental Health (MH) and Substance Use (SU), DPHHS website/personnel (list of mental health agencies, Bounds list of care sites and I/DD Type 82 providers), Medicare Compare (hospitals and nursing homes), ESRI (2022 population) & Claritas (Montana population density and land mass).

[105] "Behavioral Health Workforce Tracker."

[106] "National Directory of Mental Health Treatment Facilities 2021."

[107] "National Directory of Drug and Alcohol Abuse Treatment Facilities 2022."

[108] "Behavioral Health Workforce Tracker."

[109] "National Directory of Mental Health Treatment Facilities 2021."

[110] "National Directory of Drug and Alcohol Abuse Treatment Facilities 2022."

Table 23The implication of these analyses for future design of Montana's BH system is that, while providing more behavioral healthcare settings in communities that lack access to care is important, it is equally important to have enough BH professionals and staff in the care locations. Designing a stronger future state must solve for limited availability and access to BH providers to support care delivery throughout Montana.

Inpatient Psychiatric Care Total Population Utilization

Substantive research revealed there is limited data on benchmarks for average number of locations and space needed for various behavioral healthcare settings relative to population. To provide an understanding of typical space needs for behavioral healthcare settings per capita for peer and comparison states, the study team leveraged SAMHSA's N-MHSS (2018) and N-SSAT (2019) survey reports which provided a snapshot of average number of clients for various behavioral healthcare settings.

Comparison of Montana and national IP bed use rates per 100,000 population, as seen in Table 24, shows that:

- Montana's IP psychiatric treatment profile is different from peer states and the national average, with Montana having higher-than-average number of IP clients than the US average and other comparison states.
- Montana has a higher bed utilization than its peers as well as the national average.
- Compared to peer states, Montana has the highest utilization of IP psychiatric services per 100,000 population, suggesting a strong reliance on IP psychiatric care.

Table 24. MH Inpatient Psychiatric Utilization Analysis - Montana vs. Comparison States[111,112]

State	# of IP Facilities	# of IP Facilities per 100K	# of IP clients	IP clients/ 100K Pop	Population (2018)	Clients per Facility	Beds	Beds per 100K
Montana	**8**	**0.75**	**576**	**54.3**	**1,060,665**	**72.0**	**738**	**69.6**
North Dakota	7	0.92	293	38.7	758,080	41.9	334	44.1
South Dakota	5	0.57	169	19.2	878,698	33.8	192	21.9
Wisconsin	38	0.65	1,418	24.4	5,807,406	37.3	1,491	25.7
U.S.	**1,920**	**0.59**	**129,115**	**39.5**	**326,687,501**	**67.2**	**109,241**	**33.4**

Table Note: Data is based on pre-COVID pandemic data from 2018 and 2019 to assume typical utilization levels; retrieved mid-2023. IP facilities refers to psychiatric hospitals or psychiatric units.

Montana IP need estimates, based on national use rates, suggest that **Montana currently has adequate psychiatric bed availability,** but the beds are highly concentrated in one region of the State. If seasonal variability in demand for beds is factored into calculations (planning/target

[111] "National Mental Health Services Survey (N-MHSS): 2018: Data on Mental Health Treatment Facilities," *Substance Abuse and Mental Health Services Administration* (SAMHSA, 2017), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NMHSS-2018.pdf.

[112] Clarivate Payer Enrollment Data (2022), Claritas population data (2022).

occupancy factor of 85%-90%), **in the future, the psychiatric beds required in Montana would exceed current bed capacity.**

Comparing the share of available psychiatric beds for the Medicaid population against Medicaid enrollee utilization of beds shows that Montana, with 464 IP psychiatric beds, currently has enough beds to support average demand (see Table 25).

Montana's Medicaid population is approximately 28% of the general population. Based on national IP bed utilization rate (see Table 25), Medicaid population bed utilization should result in a demand for approximately 121 beds.

Table 25. Montana Total Population IP Psychiatric Beds Availability by Region[113]

Psychiatric Beds Available	Region 1	Region 2	Region 3	Region 4	Region 5	Total
Adult Beds (18+)	0	20	29	292	46	387
Pediatric Beds (<18)	0	0	15	30	32	77
Total (All Ages)	**0**	**20**	**44**	**322**	**78**	**464**

Table Note: Values above include forensic bed need.

Table 26. Montana Total Population IP Bed Demand Estimate by Region[114]

Psychiatric Bed Demand	Region 1	Region 2	Region 3	Region 4	Region 5	Total
Adult (18+)	25	50	77	107	122	382
Pediatric (<18)	4	8	12	13	16	53
Total (All Ages)	**29**	**58**	**89**	**120**	**138**	**435**

Table Note: Values are estimated based on pre-COVID pandemic data from 2018 and 2019 to assume typical utilization levels; retrieved mid-2023 and include forensic bed need.

Table 27. Montana Total Population IP Bed Surplus / Deficit by Region[115,116,117]

Psychiatric Bed Surplus / Deficit	Region 1	Region 2	Region 3	Region 4	Region 5	Total
Adult (18+)	-25	-30	-48	+185	-76	+5
Pediatric (<18)	-4	-8	+3	+17	+16	+24
Total (All Ages)	**-29**	**-38**	**-45**	**+202**	**-60**	**+29**

Table Note: Values include forensic bed need.

[113] *Ibid.*

[114] Clarivate Payer Enrollment Data (2022), Claritas population data (2022).

[115] *Ibid*.

[116] Christopher G. Hudson, "Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model," *International Journal of Environmental Research and Public Health* 18, no. 22 (November 20, 2021): 12205, https://doi.org/10.3390/ijerph182212205.

[117] Lutterman, T. (2022). Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2018. Technical Assistance Collaborative Paper No. 2. Alexandria, VA: National Association of State Mental Health Program Directors.

IP Psychiatric Care Utilization – Medicaid Population Claims Data

Claims data analysis of Medicaid population's IP psychiatric bed use rate in 2022, compared with bed requirements based on national use rates, indicate **under-utilization of IP psychiatric care by Montana's Medicaid population**.

Table 28 shows IP psychiatric bed availability is insufficient in four out of the five regions but estimates of overall bed availability for the Medicaid population exceeds the estimated need.

- National use rates suggest that bed demand in 2022 should result in IP psychiatric bed use of about 120 beds for the Medicaid population (see the "Inpatient Psychiatric Care Total Population Utilization" section).
- Under-utilization could be influenced by a range of factors such as lack of IP capacity, higher utilization by other segments of the population, and long lengths of stay in acute facilities leading to capacity constraints.

Table 28. Montana Medicaid Population IP Psychiatric Beds Availability by Region

Estimated Beds In-state for Medicaid Pop.	Region 1	Region 2	Region 3	Region 4	Region 5	Total
	0	6	12	89	22	129

Table 29. 2022 IP Bed Demand Estimates Based on Medicaid Enrollee Use Rate by Region

Psychiatric Bed Demand	Region 1	Region 2	Region 3	Region 4	Region 5	Total
Total	4	17	14	22	27	86*

Table 30. Medicaid Population IP Bed Deficit / Surplus by Region[118]

Psychiatric Bed Surplus / Deficit	Region 1	Region 2	Region 3	Region 4	Region 5	Total
Total	-4	-11	-2	+67	-5	+45*

Table Note: A Test of a Predictive Analytics Model |. Trends in Psychiatric Inpatient Capacity: United States and Each State, 1970 to 2018. Medicaid enrollee utilization rates is based on psychiatric IP days of care per 1,000 Medicaid enrollees in 2022. *Includes 2 beds from unknown zip codes.

SUD IP Psychiatric Care Utilization – Total Population

The assessment of SUD IP psychiatric care use rates highlights differences in Montana and comparison state's approaches to SUD IP care, showing that:

- **Montana's IP SUD treatment utilization is lower than the national average** but has similar or higher utilization of care than comparison states.
- The average SUD patient census at Montana facilities is like North Dakota's but higher than South Dakota's (see Table 31), while Wisconsin has a much lower SUD IP use rate than Montana and the national average.

[118] *Ibid.*

Table 31. SUD IP Psychiatric Utilization Analysis – Montana vs. Comparison States[119]

State	# of IP Facilities	# of IP Facilities per 100,000	# of IP Clients	IP per 100,000 Pop	Population (2019)	Clients per Facility
Montana	**3**	**0.28**	**28**	**2.6**	**1,068,778**	**9.3**
North Dakota	2	0.26	19	2.5	762,062	9.5
South Dakota	5	0.57	148	16.7	884,659	29.6
Wisconsin	6	0.10	74	1.3	5,822,434	12.3
U.S.	**459**	**0.14**	**11,344**	**3.5**	**328,239,523**	**24.7**

Table Note: Data is based on pre-COVID pandemic data from 2018 and 2019 to assume typical utilization levels; retrieved mid-2023.

SUD Residential Total Population Utilization – Montana vs. Comparison States

A similar assessment of SUD residential beds per 100,000 population showed that:

- Behavioral healthcare should be provided in the least restrictive care setting, but Table 32 shows that **Montana has lower utilization of sub-acute SUD residential care**, which is significantly different from its neighboring states.
- Future ecosystem design in Montana must consider increasing access to SUD residential care, which has the dual benefit of providing SUD care in a less acute care setting in the community and potentially freeing up IP beds for other acute needs.

Table 32. SUD Residential Utilization-– Montana vs. Comparison States

State	# of Residential SUD Facilities	# of Residential SUD Facilities per 100K Clients	Total clients in treatment -Residential SUD	Total Residential SUD Clients per 100K State Population	Population (2019)	Clients per Facility
Montana	**12**	**1.1**	**243**	**22.7**	**1,068,778**	**20.3**
North Dakota	21	2.8	307	40.3	762,062	14.6
South Dakota	13	1.5	299	33.8	884,659	23.0
Wisconsin	35	0.6	1,266	21.7	5,822,434	36.2
U.S.	**2,710**	**0.8**	**83,877**	**25.6**	**328,239,523**	**31.0**

Table Note: Uses pre-COVID data from 2018 and 2019 to assume typical utilization levels; retrieved mid-2023.

MH Residential Total Population Utilization – Montana vs. Comparison States

The following bullets summarize findings about MH residential total population utilization in Montana as compared to comparison states.

- Montana's residential MH care settings profile differs from peer states and nationally.

[119] "National Mental Health Services Survey (N-MHSS): 2018: Data on Mental Health Treatment Facilities."

- In comparison with comparison states, Table 33 shows that **Montana has the second highest utilization of residential MH services** per 100,000 population.
- The analysis presented in Table 33, coupled with previous analyses, suggests that part of Montana's challenge with access to care is related to maldistribution of MH residential care across the State's regions.
- Despite Montana's higher MH residential care utilization than North Dakota, Wisconsin, and the national average, future design considers Montanan's need for access to BH care settings in the communities where live. **Addressing deficits in care in the regions that lack MH residential care is necessary**, especially for the Medicaid population.

Table 33. MH Residential Utilization – Montana vs. Comparison States

State	# of Residential Facilities	# of Residential Facilities per 100K	# of Residential Clients	24-Hour Residential Clients/ 100K	Population (2018)	Clients per Facility	Beds	Beds per 100K
Montana	**21**	**1.98**	**444**	**41.9**	**1,060,665**	**21.1**	**638**	**60.2**
North Dakota	10	1.32	169	22.3	758,080	16.9	173	22.8
South Dakota	7	0.80	372	42.3	878,698	53.1	375	42.7
Wisconsin	25	0.43	825	14.2	5,807,406	33.0	824	14.2
U.S.	**1,932**	**0.59**	**58,762**	**18.0**	**326,687,501**	**30.4**	**62,253**	**19.1**

Table Note: Values are based on pre-COVID pandemic data from 2018 and 2019 to assume typical utilization levels; retrieved mid-2023.

MH Partial Hospitalization Total Population Utilization – Montana vs. Comparison States

The following bullets summarize findings about MH partial hospitalization total population utilization in Montana as compared to comparison states.

- Like other analyses, Montana **has the highest ratio of MH partial hospitalization / day treatment facilities** compared to North Dakota, South Dakota, and Wisconsin, as shown in Table 34.
- However, while this observation is theoretically positive, it must be understood in context. Like other analyses have shown, **substantial portions of the State lack access to PHP services**, especially for the Medicaid population (see Table 34). This service requires multiple visits per week for an extended period, which is a burden for transportation challenged regions.

Table 34. MH Partial Hospitalization Utilization – Montana vs. Comparison States

State	# of less than 24-hour PH/day Treatment Facilities	# of less than 24-hour PH/day Treatment Facilities per 100,000	Number of Clients in less than 24-hour PH/day Treatment Facilities	Number of Clients in less than 24-hour PH/day Treatment Facilities per 100,000 state pop	Population (2018)
Montana	**5**	**0.471**	**--**	**--**	**1,060,665**
North Dakota	1	0.132	--	--	758,080
South Dakota	0	0.000	--	--	878,698
Wisconsin	13	0.224	--	--	5,807,406
U.S.	**349**	**0.107**	**28,483**	**8.7**	**326,687,501**

Table Note: Values are based on pre-COVID pandemic data from 2018 and 2019 to assume typical utilization levels; retrieved mid-2023. Blank cells indicate that no data was available.

SUD Partial Hospitalization Total Population Utilization – Montana vs. Peer/Comparison States

In contrast to Montana's MH PHP care utilization, **Montana's ratio of SUD day treatment/ partial hospitalization**, as seen in Table 35, is similar to the national average, but it **is lower than the ratios seen in North Dakota, which scores higher than Montana on SUD outcome measures** (see Table 12). This indicates that there may be an opportunity for Montana to increase the number of care settings that make this service available.

Table 35. SUD Partial Hospitalization Utilization – Montana vs. Comparison States

State	# of Day Treatment or PHP Facilities	# of Day Treatment or PHP Facilities per 100,000 Pop (2019)	Total Clients in Treatment – Day Treatment or PHP (2019)	Total PHP or Day Treatment Clients per 100,000 State Pop (2019)	Population (2019)	Clients per Facility
Montana	**6**	**0.6**	**62**	**5.8**	**1,068,778**	**10.3**
North Dakota	22	2.9	98	12.9	762,062	4.5
South Dakota	7	0.8	58	6.6	884,659	8.3
Wisconsin	31	0.5	282	4.8	5,822,434	9.1
U.S.	**2,255**	**0.7**	**19,973**	**6.1**	**328,239,523**	**8.9**

Table Note: Values are based on pre-COVID pandemic data from 2018 and 2019 to assume typical utilization levels; retrieved mid-2023.

SUD Intensive Outpatient Total Population Utilization – Montana vs. Comparison States

The following bullets summarize findings about SUD IOP total population utilization in Montana as compared to comparison states.

- Montana's ratio of IOP SUD facilities and clients relative to population, as seen in Table 36, is higher than the national average, Wisconsin, and North Dakota.
- The utilization rates show a partial picture of Montana's access to SUD IOP care challenges. As seen in Table 36, large portions of Montana do not have ready access to

this service, which requires multiple visits per week for an extended period, which becomes is a burden for transportation challenged regions.

- Considering Montana's low ranking in SUD outcomes (see Table 12), it can be inferred that there are additional factors driving Montana's utilization rates. Table 36 shows one underlying factor that substantial portions of the State do not have IOP coverage. Future planning requires increased access to IOP in regions with not IOP coverage and a multidisciplinary approach to reduce prevalence of SUD.

Table 36. Intensive Outpatient Utilization – Montana vs. Comparison States

State	# of Intensive OP SUD Facilities	# of Intensive OP SUD Facilities per 100,000 Pop	Total Clients-Intensive OP SUD (2019)	Total Intensive OP SUD Clients per 100,000 Pop (2019)	Population (2019)	Clients per Facility
Montana	**41**	**3.8**	**492**	**46.0**	**1,068,778**	**12.0**
North Dakota	42	5.5	309	40.5	762,062	7.4
South Dakota	34	3.8	585	66.1	884,659	17.2
Wisconsin	97	1.7	1,120	19.2	5,822,434	11.5
U.S.	**7,325**	**2.2**	**130,343**	**39.7**	**328,239,523**	**17.8**

Table Note: Data is based on pre-COVID pandemic data from 2018 and 2019 to assume typical utilization levels; retrieved mid-2023.

2022 State Facilities and Medicaid Population Bed Use and Patient Origin

The study team completed additional data analysis using State facilities data (MICRS) and Medicaid claims data to evaluate the utilization of behavioral healthcare settings, space required to support care used, as well as regional variations in behavioral healthcare utilization. Based on analysis of Medicaid claims data of enrollees with a BH and/or I/DD diagnosis, findings corroborated insights drawn from previous analyses regarding disparities in access to care.

Medicaid Enrollees IP - Current Bed Utilization

Medicaid enrollee service utilization varies across regions.

- Lower IP utilization plus higher OP utilization by Region 1 Medicaid enrollees may point to issues in accessing IP BH services close to home, leading to increased reliance on OP care settings. This suggests a need for IP behavioral healthcare setting in closer proximity to where individuals reside.
- Figure 42, an analysis of 2022 Medicaid claims data, shows that availability of access points impact utilization of BH services. Observed variation in utilization is related to number of BH access points available as well as other factors.
- Stakeholder feedback received during Subcommittee meetings indicated that observed variation in utilization was due to lack of access to some behavioral healthcare settings and lack of confidence in capability of current behavioral healthcare settings to provide quality care in some communities thus leading to under-utilization of needed care, foregone care, overutilization of other care settings that are more readily available in the community, or outmigration for care - residents traveling outside their home regions to receive care.

Figure 42. 2022 Medicaid Behavioral Healthcare Utilization Rates for Medicaid Enrollees[120]

Figure Note: Medicaid behavioral healthcare activity utilization rates for individuals with a BH or I/DD diagnosis. Values shown are per 1,000 Medicaid Enrollees. PB = Professional Billing.

Role of Montana State Government in Behavioral Healthcare Access

The State of Montana provides acute psychiatric care through MSH and provides other behavioral healthcare services through MT MH Nursing Care Center, MT IBC, and MT Chemical Dependency Center. The other behavioral healthcare sites are considered sub-acute care settings because they do not provide a hospital day but provide more services than are found in other community-based behavioral healthcare settings for routine BH services. The State of Montana participates in the BH ecosystem and care continuum through the four state facilities and reimbursement of IP and residential services used by Medicaid enrollees. Based on analysis of the State facilities data (MICRS) three of the four State BH facilities accept civilly committed patients, which is a feature that is not universally available in care settings operated by private BH entities.

Analysis of State facilities data confirmed that a substantial proportion of the patients at Montana State facilities are involuntarily admitted or forensic patients. One of the core goals of the design study was to evaluate opportunities to transition behavioral healthcare for individuals to the most appropriate care setting (less institutional/acute) that would foster reintegration into communities and society.

Study analytics demonstrated opportunities to create care sites that are readily accessible in areas and communities with unfulfilled needs may be limited due to low relative population and the resulting low demand/census. Furthermore, if utilization and space need for sub-populations such as pediatrics, individuals with SMI, and Tribal populations are further parsed out for each region, establishing independent access points to cover each specific need is much less feasible. This is especially true of Regions 1 and 2, which have significant care gaps and are sparsely populated.

[120] MMIS Medicaid claims data, ESRI population data, Clarivate (Medicaid Enrollees)

Table 37. 2022 State Facilities and Medicaid Bed Use by Region[121]

Care Setting	Reg. 1	Reg. 2	Reg. 3	Reg. 4	Reg. 5	Outside / Unknown	Total
MSH	14	30	45	75	88	19	271
MT MH Nursing Center	4	2	67	7	4	1	85
MT IBC	2	1	0	8	2	0	13
MT Chemical Dependency Center	4	8	4	10	4	0	30
Medicaid - IPs	4	17	14	22	27	2	86
Medicaid - Residential	11	39	27	32	49	1	159
Total Beds in Use	**39**	**97**	**157**	**154**	**174**	**23**	**644**

Table Note: Current space demand assumes 85% occupancy rate to allow for seasonal variation in demand for beds. Residential beds include SUD residential, MH residential, group homes, and other congregate settings involving an overnight stay (excluding ED visits). Values may not add up to "Total" due to rounding. Medicaid - IPs refers to acute facilities (hospitals) in the Medicaid claims data that provided days of care to Medicaid enrollees in 2022. Medicaid - Residential facilities refers to non-hospital facilities that provided overnight stay services to Medicaid enrollees with BH diagnoses.

Montana State Hospital – The role of MSH in Montana's BH System

MSH is at the top of the behavioral healthcare continuum acuity pyramid as it supports treatment of the most complex psychiatric conditions that other psychiatric hospitals may not be able to or equipped to address. With 270 beds, it has the highest volume of acute psychiatric beds in the State. Per State officials, MSH is often at capacity and DPHHS has reported staffing challenges and limited capacity to accommodate demand for BH services, resulting in growing demand of a bed of individuals in EDs, jails, prisons, and deferred referrals and care from community-based providers.

MSH is geographically isolated, which makes access and post-discharge planning challenging. In 2022, the State hospital lost its Centers for Medicare and Medicaid Services (CMS) accreditation due to safety, quality of care, and financial challenges. Accreditation loss is financially detrimental, requiring the State to fully-fund MSH operations with limited to no federal off-set. Many of the factors that led to MSH's loss of accreditation – which developed over decades – highlight the challenges within the current inpatient-centric care model, which is not sustainable or scalable as a primary BH solution for the State.

MSH only accepts forensic or involuntarily committed patients. As such, individuals in need of comprehensive acute psychiatric care have limited alternate options for care. Feedback received from stakeholders indicate that other psychiatric care sites sometimes lack the resources to serve more complex behavioral healthcare needs, sometimes resulting in individuals not seeking care or being involuntarily committed as a last resort.

[121] Medicaid claims data (inpatient, outpatient, and professional billing) for enrollees with a BH or I/DD diagnosis in CY 2022.

MSH Current Bed Utilization

The following bullets summarize findings about MSH current bed utilization.

- Analysis of MSH data (see Figure 43 and Table 37) suggests **there may be enough demand to support more than one psychiatric hospital in the State**.
- Regionalizing care may result in inefficiencies, as it would require duplicating support services and fixed capital assets and structures across a wide geography.
- A substantial portion of patient care days at MSH are for justice-involved patients, which may pose challenges for making care available closer to an individual's home. Due the justice system's involvement, the opportunity to address the needs of the patients in sub-acute, non-secure settings in the community may be limited.
- This analysis does not reflect the growing demand in EDs, other parts of the justice system (jails and prisons), or forgone care.

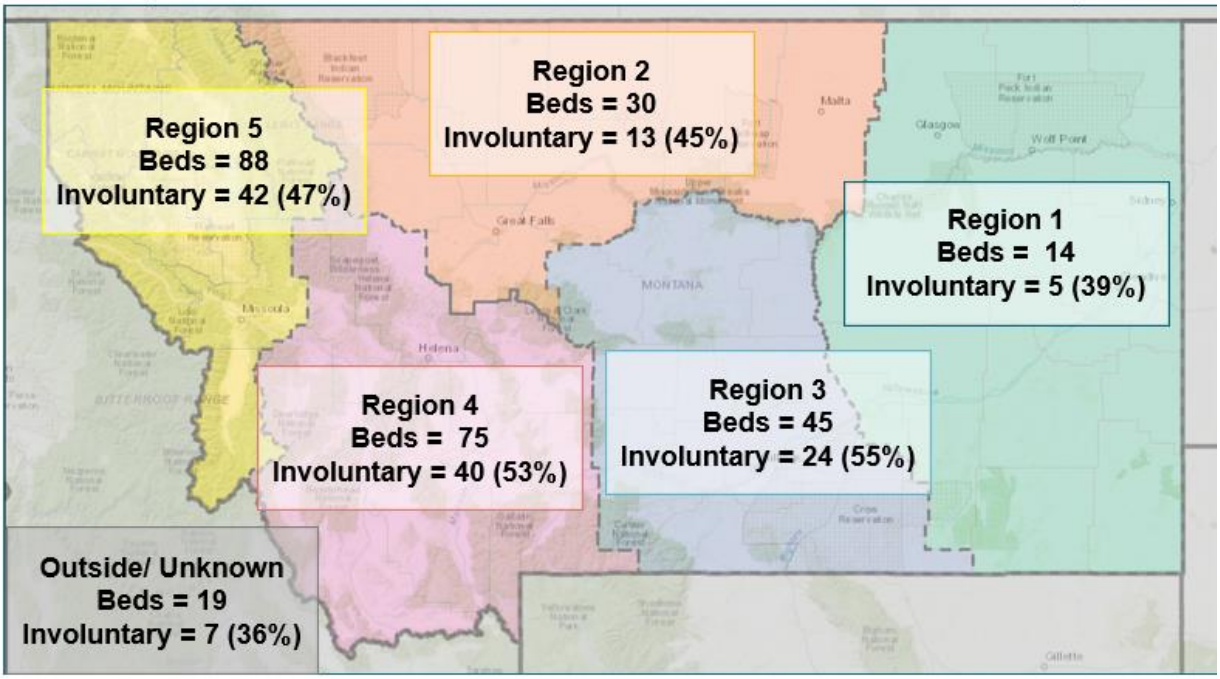


Figure 43. MSH Patients' Bed Need by Patient Origin and Commitment Status[122]

Figure Note: Values reflect calendar year (CY) 2022 total patient days of care at the facility, regardless of diagnosis. Current space demand assumes 85% occupancy rate to allow for seasonal variation in demand for beds. Involuntary shows number of beds required for involuntary patients and the percentage value is the share of involuntary patient days of care for "court," "civil," "emergency," "alcohol," "commitment," and Tribal nation commitments listed in MICRS data set. MSH patients include all insurance types.

State Facilities and Medicaid Enrollees Current Bed Demand

- MICRS and Medicaid data show regional care needs may support the case for regionalization of acute and sub-acute care settings across the State, especially for MSH patients and Medicaid enrollees.

[122] MICRS (State Facilities) data

- However, low population in Region 1 may have a challenge to providing acute and sub-acute care locally. There may be opportunity to leverage other entities in the BH ecosystem to address care gaps.
- Opportunity to create feasible access points may be further limited if sub-population such as pediatric and SMI are considered independently of the collective behavioral healthcare need.
- Facilities outside the State make include 16 IP beds and 56 residential beds that serve Montana Medicaid enrollees in need of behavioral healthcare.
    - 14 of the IP beds are for the pediatric population and 44 of the residential beds are for ages 13-17 and 12 beds are for ages 12 and younger.

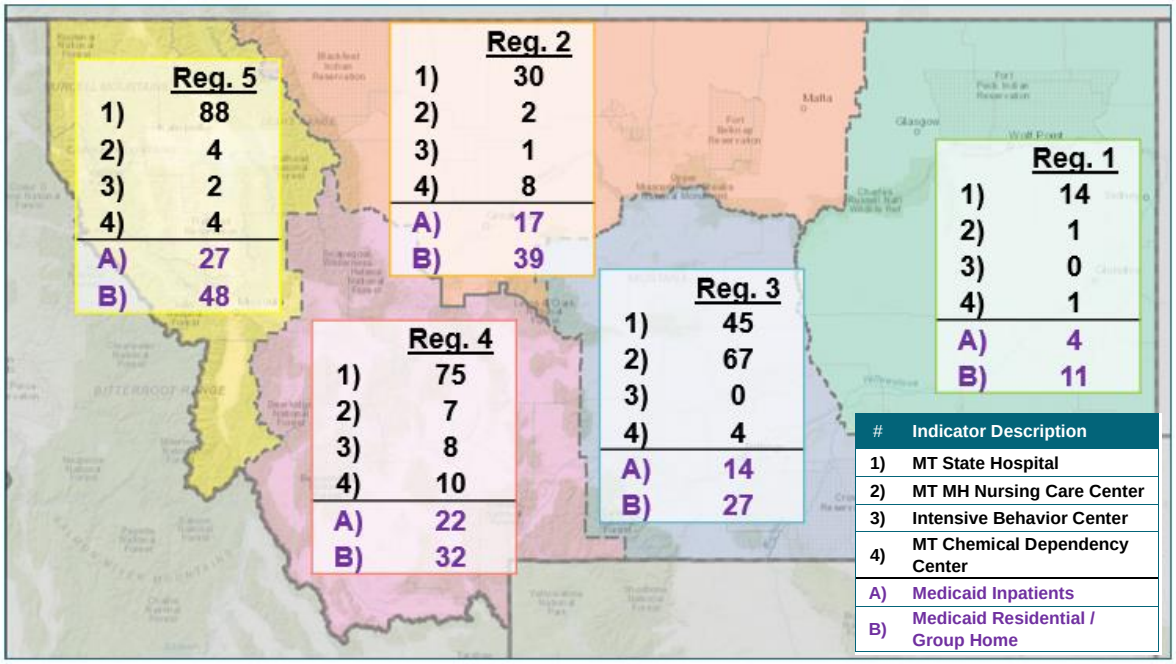


Figure 44. 2022 State Facilities and Medicaid Enrollees Current Bed Demand[123]

Figure Note: Current space demand assumes 85% occupancy rate to allow for seasonal variation in demand for beds. Residential beds include SUD residential, MH residential, group homes and other congregate settings involving an overnight stay (excluding ED visits).

Medicaid Enrollees Current Space Demand

- Medicaid data shows there is enough demand to support having more distributed acute and sub-acute care settings across the State.
- However, parsing out space needs based on sub-populations, such as pediatrics, SMI, may limit ability to increase access closer to patient's home in some regions.
- Medicaid enrollees currently require approximately 90 IP beds and approximately 160 overnight stay (residential/group home) beds to support current activity.

[123] Medicaid claims data (inpatient, outpatient, and professional billing) for enrollees with a BH or I/DD diagnosis in CY 2022

- Low bed utilization in Region 1, (see Figure 45) limits opportunity for creating access point(s) closer to patients' home.

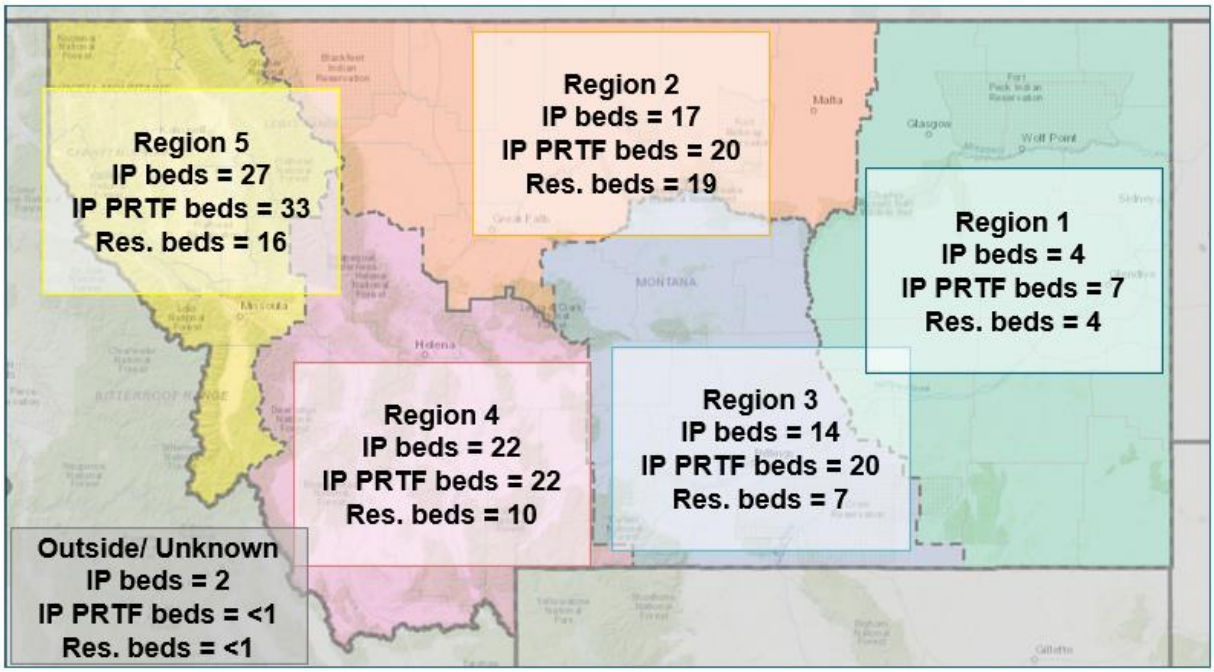


Figure 45. 2022 Medicaid Enrollees Space Demand – PRTF and Other Residential Care[124]

Figure Note: Based on Medicaid claim data (inpatient, outpatient, and professional billing) for enrollees with a BH or I/DD diagnosis in CY 2022. Current space demand assumes 85% occupancy rate to allow for seasonal variation in demand for beds. PRTF = psychiatric residential treatment facility. Residential beds include SUD residential, MH residential, group homes and other congregate settings involving an overnight stay (excluding ED visits) reported in Medicaid professional billing claims.

Medicaid Pediatric Out-of-State Care Utilization - 2022 Bed Demand

Examination of Medicaid claims data showed that many pediatric patients enrolled with BH and I/DD conditions were receiving care that required overnight stays from out-of-state facilities. Figure 46 shows the number of beds that would be required by region for all the days that were provided to the pediatric population by IP and residential facilities located outside the state of Montana. Residential facilities in this context refer to any site providing overnight stay services but are not classified as hospitals. For example, pediatrics in Region 5 received residential BH services at centers outside the state equivalent to days of care that could fill 17 beds. This means that if Montana were to create a facility in the region to meet the demand for residential pediatric services in 2022, the facility would require 17 beds equipped with the resources, workforce, and expertise required to meet the needs of pediatrics of that region who received care out-of-state.

- The map in Figure 46 shows the bed demand for IP and residential services for pediatric Medicaid enrollees who received services from out-of-state facilities by region.
- There is large enough demand to provide care for pediatric clients who currently leave Montana for care, while utilizing limited workforce and capital resources efficiently.

[124] Medicaid claims data (inpatient, outpatient, and professional billing) for enrollees with a BH or I/DD diagnosis in CY 2022

- If out-of-state care volume is brought back into the State, limited region-specific access to residential services may be an option for implementation.
- However, low bed demand shown in Figure 46 indicates it may not be feasible to provide in-state pediatric care in each of the five regions. Most regions show enough need for pediatric residential services to support a small facility except for Region 1. Region 1 shows a need for three residential beds for those pediatric populations who received residential care from out-of-state institutions. Creating a four-bed residential setting equipped with the right resources and workforce for a small client census would require significant consideration prior to implementation.

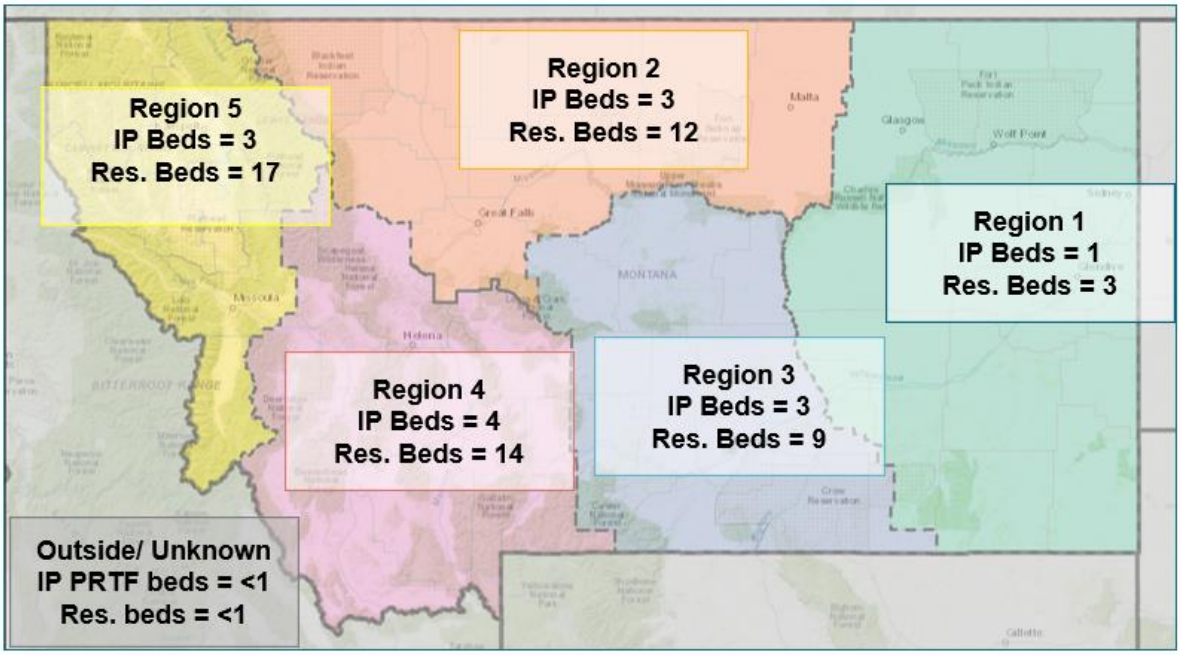


Figure 46. Pediatric Medicaid Enrollees at Out-of-State Facilities – Current Bed Demand Based on Region of Origin[125]

Figure Note: Current space demand assumes 85% occupancy rate to allow for seasonal variation in demand for beds. Residential beds include SUD residential, MH residential, group homes and other congregate settings involving an overnight stay (excluding ED visits). Pediatrics include ages 0 to 17.

2022 Medicaid Population Bed Use Requirements for Tribal and Adjacent Lands

- Data analysis shows that current BH space utilization for Medicaid enrollees residing on Tribal and adjacent lands is small (See Table 38).
- There is an **opportunity to provide culturally relevant and sensitive care to residents of Tribal lands.** The provision of care may require pooling and consolidation of space needs across the different nations for economies of scale and efficiency.
- Individually, the need for space to support patient activity from each of the Tribal nations is often not large enough for operations to have substantial efficiency.
- However, when space utilization is aggregated across the Tribal nations shown in Table 38, there may be enough critical mass of patient activity to realize economies of scale.

[125] Medicaid claims data (inpatient, outpatient, and professional billing) for enrollees with a BH or I/DD diagnosis in CY 2022.

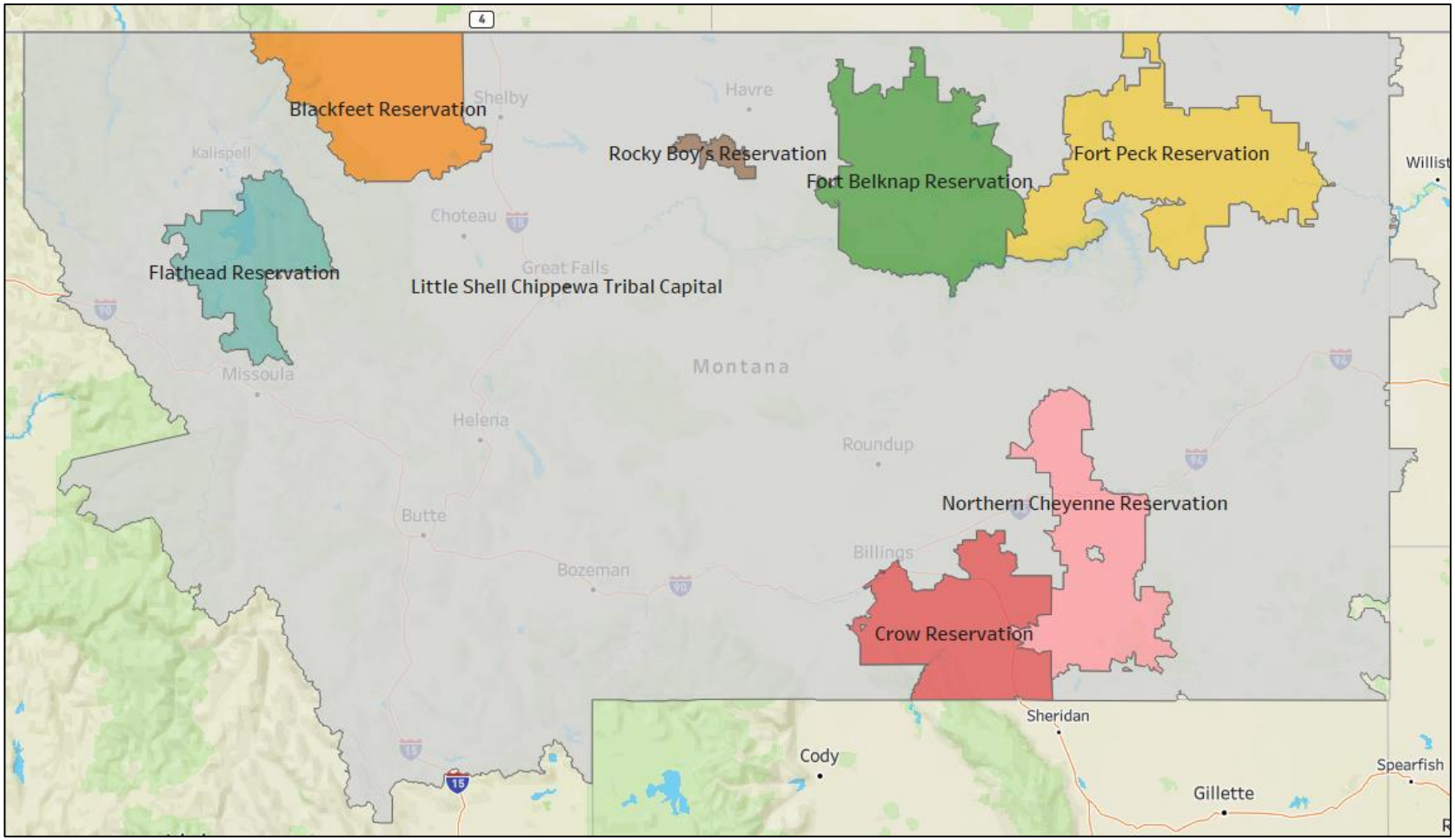


Figure 47. 2022 Map of Tribal Lands, Including Adjacent Zip Codes[126]

Figure Note: Map shows Tribal reservation zip codes and zip codes adjacent to reservations that have a significant Tribal presence (validated by DPHHS). Many Tribal members who utilize Medicaid services use addresses that are in zip codes adjacent to Tribal lands.

[126] Medicaid claims data (inpatient, outpatient, and professional billing) for enrollees with a BH or I/DD diagnosis in CY 2022.

Table 38. 2022 Medicaid Bed Use Requirements for Tribal and Adjacent Lands[127]

Reservation / Tribal Capital	MSH	Medicaid IP Beds	Medicaid Residential Beds
Blackfeet	5	2	4
Crow	17	7	11
Flathead	12	3	4
Fort Belknap	3	2	3
Fort Peck	4	1	3
Little Shell Chippewa	9	2	3
Northern Cheyenne	1	<1	1
Rocky Boy's	1	<1	<1
Total	53	18	29

Table Note: Current space utilization assumes 85% occupancy rate to allow for seasonal variation in utilization for beds. Residential beds include SUD residential, MH residential, group homes, and other congregate settings involving an overnight stay (excluding ED visits). Values may not add up to "Total" due to rounding.

Medicaid Patient Origin vs. Service Location Assessment

Distance from where residents live to where behavioral healthcare centers are located affects out-migration for care patterns. Medicaid enrollees' data analysis showed the following insights about availability of access points in the regions and its impact on where patients sought behavioral healthcare.

- Significant out-migration for care, shown in Figure 48 and Figure 49 illustrate that residents of Regions 1 and 2 are more likely to leave their region for BH services. The population's tendency to receive behavioral healthcare outside their home region indicates a gap in access to care or level of care desired by residents of that region.
- Individuals with BH conditions prefer to obtain care close to home, or if services are not accessible, will travel to the closest region or out-of-state for care (see Figure 48).
- Medicaid enrollees in Regions 1 and 2 are more likely to travel outside their home regions for care, while residents of other regions are more likely to receive services in their region. Previous analyses show that Regions 3, 4, and 5 have more IP behavioral healthcare sites than Regions 1 and 2 which can explain the lower level of outmigration for services. why these residents show lower levels of outmigration.
- Residents of Regions 2 and 4 are more likely to seek IP residential care from out-of-state entities. This data suggests that there is a gap in access to this type of sub-acute care in the regions and the State.

[127] *Ibid.*

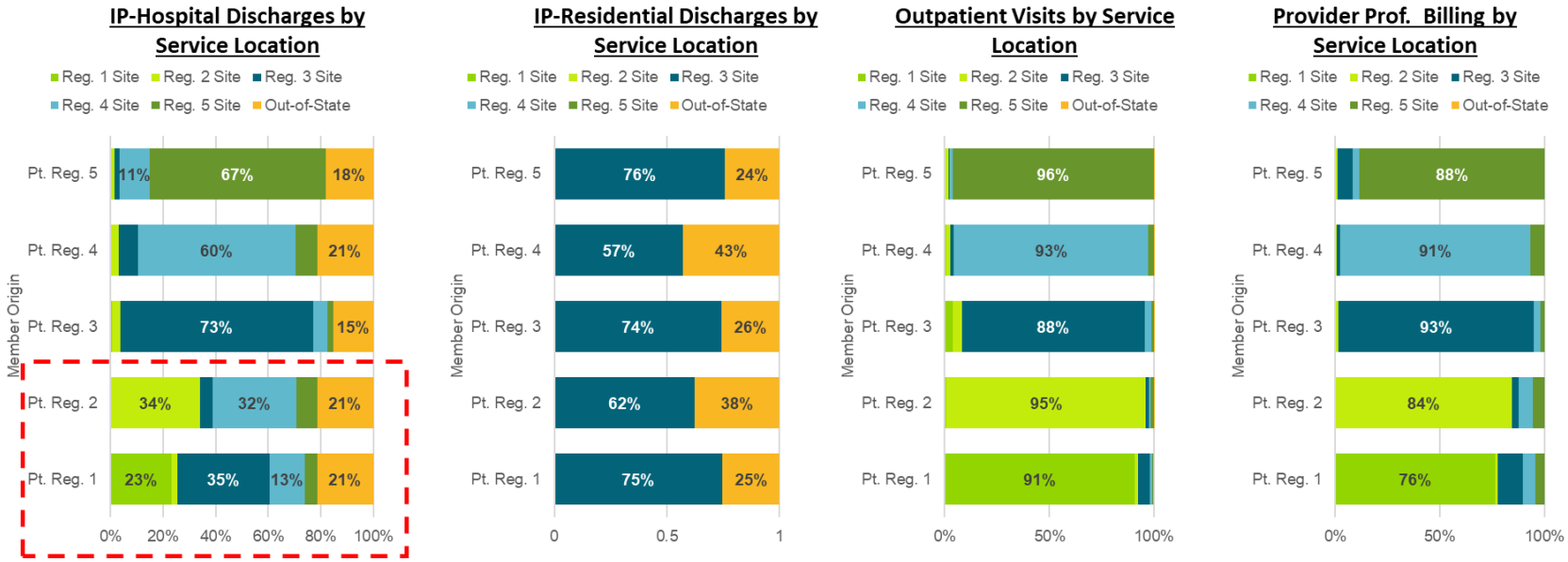


Figure 48. 2022 Inpatient, Outpatient, and Professional Medicaid Billing Activity by Location[128]

[128] MMIS Medicaid claims data, ESRI population data

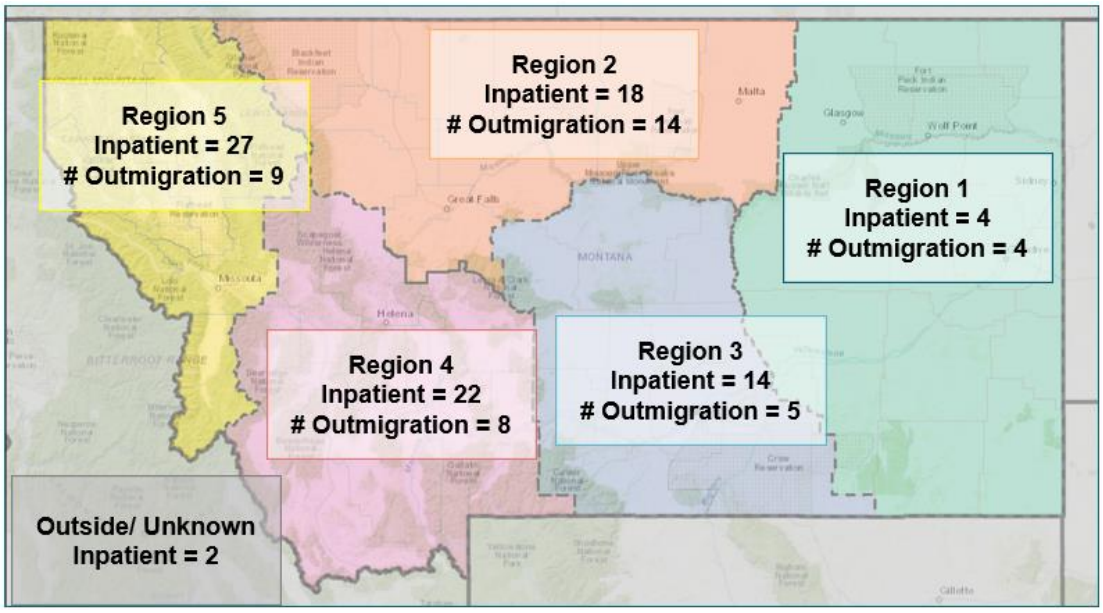


Figure 49. 2022 Medicaid Enrollees Inpatient Bed Use with Out-Migration Detail[129]

Figure Note: Current space demand assumes 85% occupancy rate to allow for seasonal variation in demand for beds. Out-migration is the demand for beds by patients who left their home region to receive care from sites outside their region.

Facility Planning Implications

Certain areas of the State consistently have service coverage gaps in access to the full continuum of BH, as seen in Figure 50. **Creating multiple independent care sites to address coverage deficits is not feasible and would be a costly approach to addressing these BH service deficits**.

[129] Medicaid claims data (inpatient, outpatient, and professional billing) for enrollees with a BH or I/DD diagnosis in CY 2022.

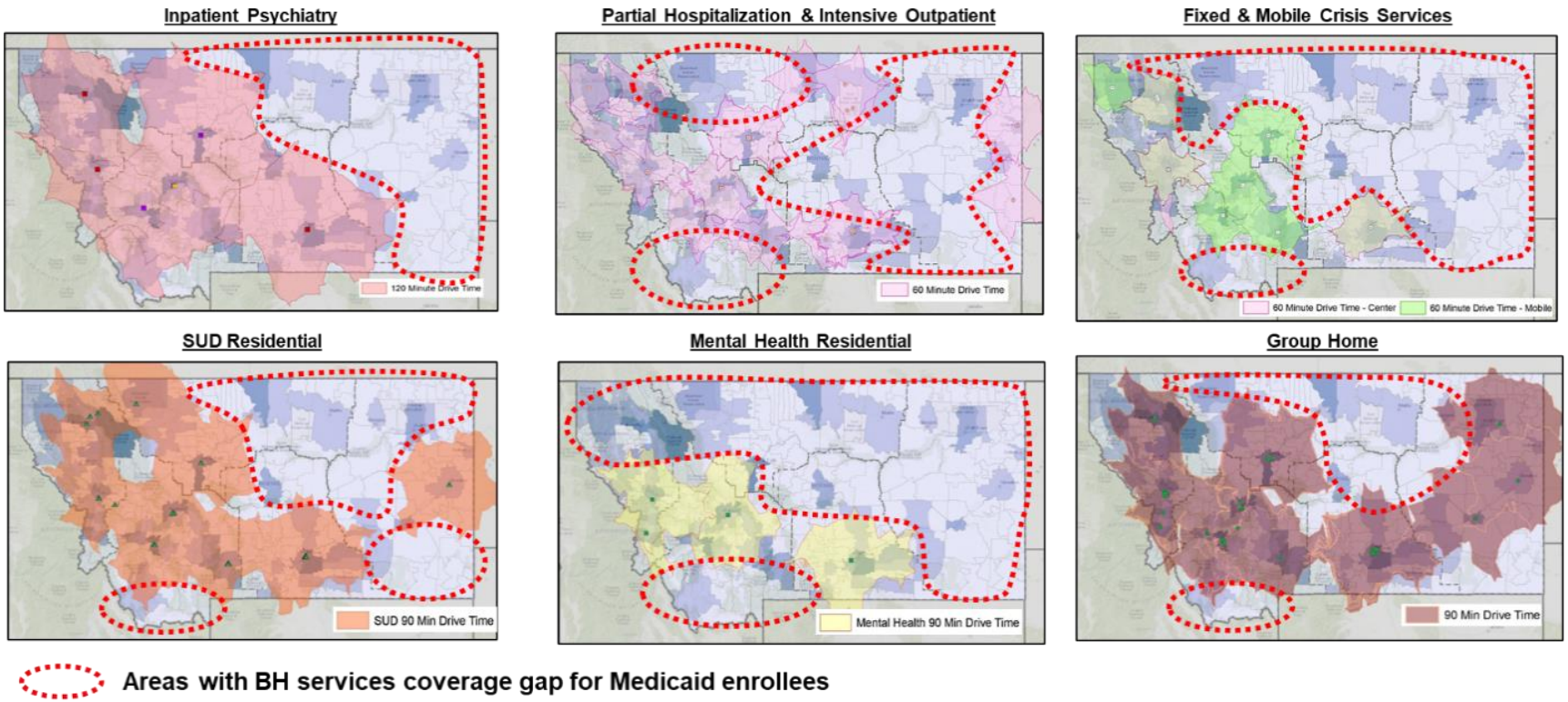


Figure 50. Overview of Key Behavioral Healthcare Settings Gaps in Montana[130]

[130] Medicaid claims, DPHHS, SAMHSA, Medicare Compare, and other public sources as of November 2023, Clarivate.

Addressing Sub-Acute and Outpatient Behavioral Healthcare Deficits

When considering locations of new BH sites of care, data analysis suggests co-location of services to address multiple behavioral healthcare continuum gaps at one site may be a more cost–effective approach. It has the potential to address gaps in access to BH services for communities with low population density. It also offers economies of scale, optimizing the use of limited workforce in these areas.

- Potential sites identified in Figure 51 are areas where multiple behavioral healthcare settings are absent in those areas.
- Co-locating services or providing services near each other, especially in the eastern and northern parts of the State, could optimize limited workforce and funding resources due to greater ability to share resources.
- If implemented, the scope of services and size of the population in the catchment area of the new site would determine the size of new sites (see Figure 51).

Potential Co-location Site Nuances

Specific to recommending which regions to invest in first, the design study team quantified services needed and volumes to be served, which differ in magnitude, by region, and site. Thus, there is a need to consider phased implementation – impacting a higher volume of prospective patients or introducing care where there is less access.

- **Sites B, C, and E** –These sites have the largest deficits in the range of BH services provided (see Figure 52). Residents in these areas have lower population density, limited workforce, and the geographic need to travel farther to receive behavioral healthcare. From the perspective of breadth of behavioral healthcare services missing, providing care at these locations would be the priorities.
- **Site A** – This site has the largest population and therefore the highest estimated demand for BH services / space needs. However, it is important to note that Site A's catchment area, because of the size of the drive-time circle, includes areas that have some degree of service coverage for the complement of services identified (see Figure 51). To reach the broadest population, this site may be prioritized for implementation first.
- **Site F** – This site's catchment area is missing many BH services, but it is between two multi-setting care sites' catchment areas. Therefore, the true area lacking behavioral healthcare is a portion of the estimated need displayed. Addressing care gap needs in this area could potentially benefit from transportation supports or the leverage of technology to extend / strengthen the reach and support of existing providers to individuals in these communities.
- **Site D** – This site has the lowest population in its catchment area, resulting in exceptionally low estimated demand / space needs, which could introduce feasibility issues. It may be beneficial to enhance transportation services in this area to extend services or partner with local providers to support the needs of the population.

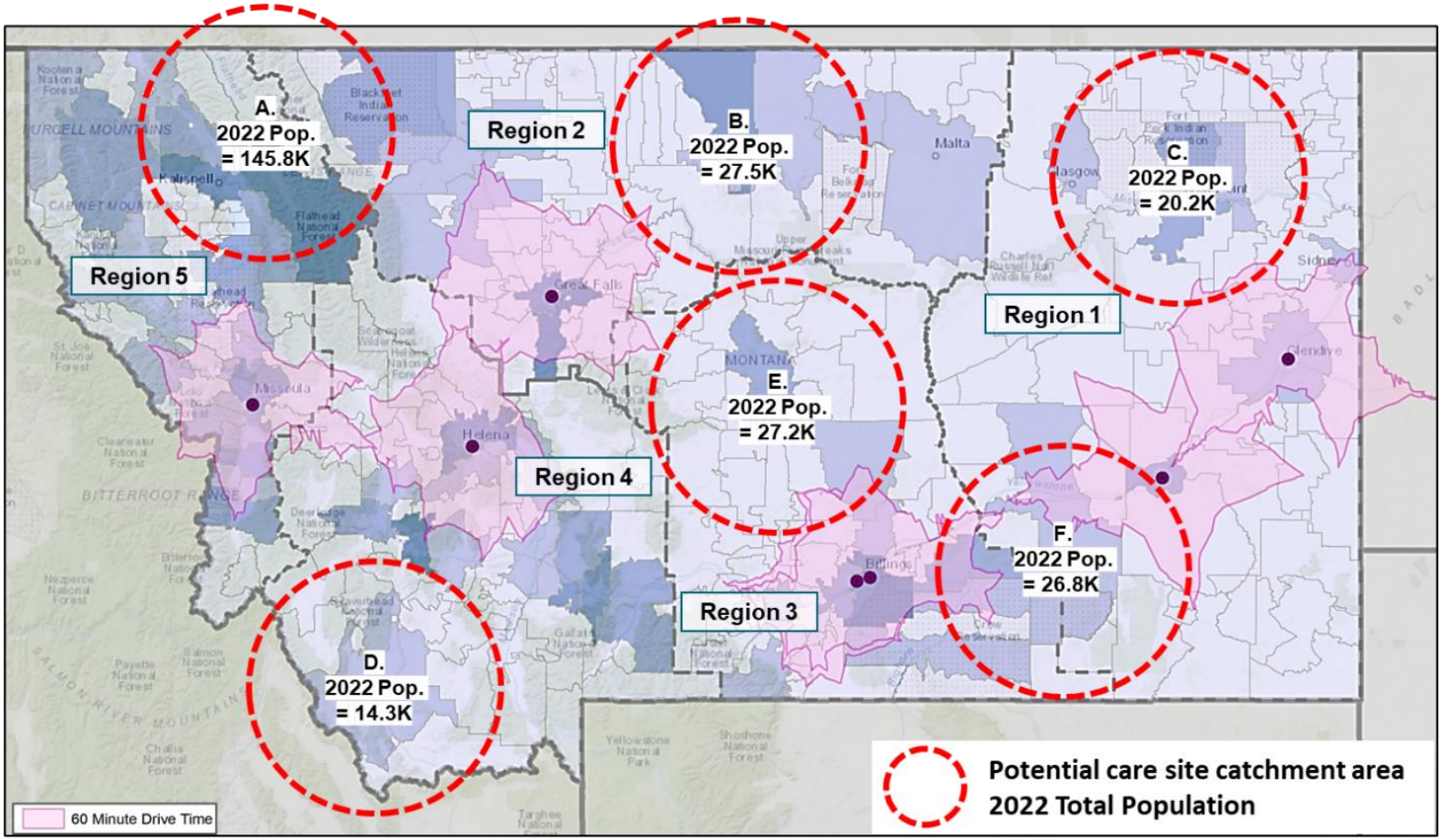


Figure 51. Potential Care Site Catchment Areas Compared to Population[131]

Figure Note: The map background indicates the percent of Medicaid enrollees (2022) by zip code. The darker the color, the greater percent of Medicaid enrollees.

[131] Medicaid claims, DPHHS, SAMHSA, Medicare Compare, and other public sources as of November 2023, Clarivate.

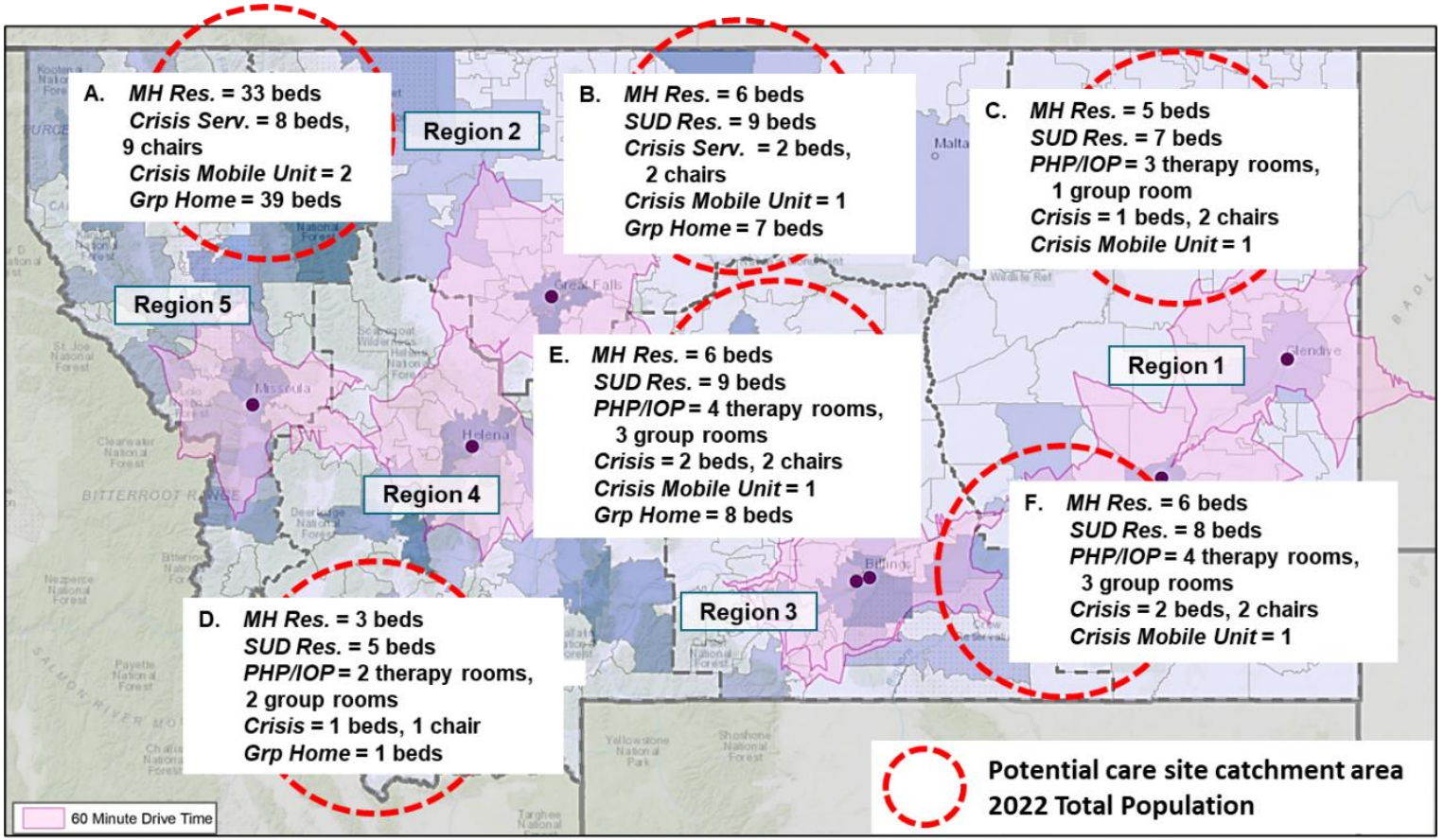


Figure 52. Proposed Sub-Acute Care Sites

Figure Note: KPU calculations are based on data from SAMHSA's N-MHSS (2018) and N-SSAT (2019) surveys and Crisis Resource Need Calculator (crisisnow.com). Other resources include Claritas and Clarivate (2022 Medicaid Enrollees). KPUs shown in boxes are for projected total population (2032) in the catchment area of the proposed behavioral healthcare sites. KPUs are based on planning occupancy rate ranges from 50%-65% for therapy rooms and 85%-90% for overnight stay beds; the rate applied varies with type of behavioral healthcare setting and rural vs. urban occupancy expectations. Group session space requirement estimates are based on research from sample weekly schedules for PHP and IOP providers.

Montana BH Access Delivery System - Key Findings

Below is a list summarizing the BH access delivery system key findings.

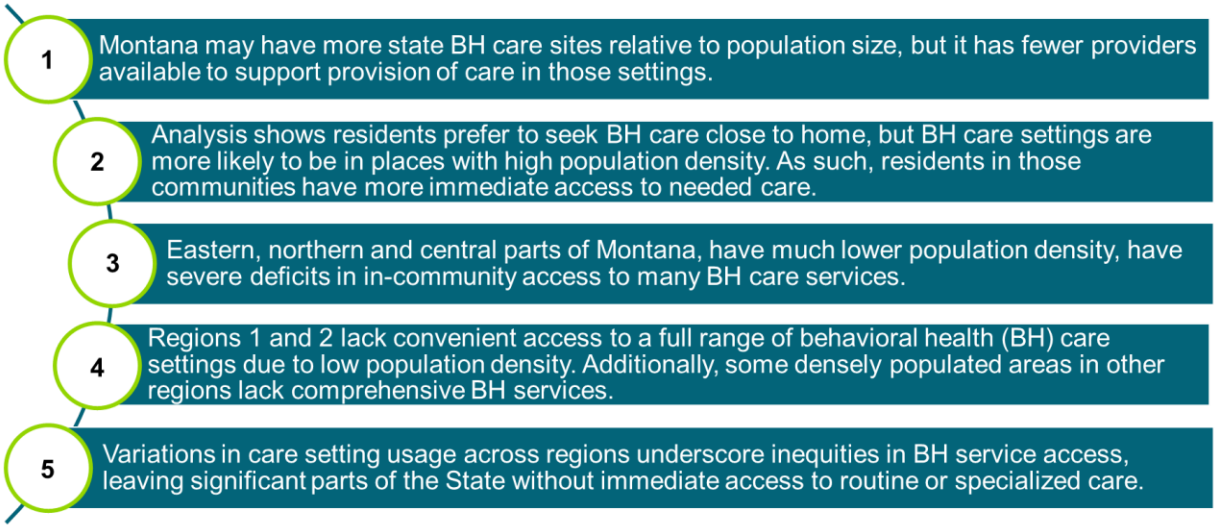


Figure 53. Montana BH Access Delivery System - Key Findings

Workforce

Measuring the Supply of BH Workforce

BH workforce is an integral part of the Montana BH ecosystem. They staff care settings and coordinate individuals' progression throughout the care continuum. Understanding state and regional workforce deficits is critical to designing a stronger BH system.

Understanding Montana's BH Workforce

In examining physical access to behavioral healthcare challenges across the State, the study team needed to look beyond the number of physical care locations and their relative availability in Montana's regions. To assess the effectiveness of these locations to serve as access points for behavioral healthcare services, the study team examined the BH provider and workforce environment to understand where the workforce is located and their related challenges. Furthermore, care locations without BH providers and staff to provide care and services would be ineffective in addressing issues in the ecosystem.

Reviewing health professional shortage data from HPSA, depicted in Figure 54, show that while all counties in Montana are designated as Mental Health Professional Shortage Areas, it is especially pronounced in the eastern part of the State.

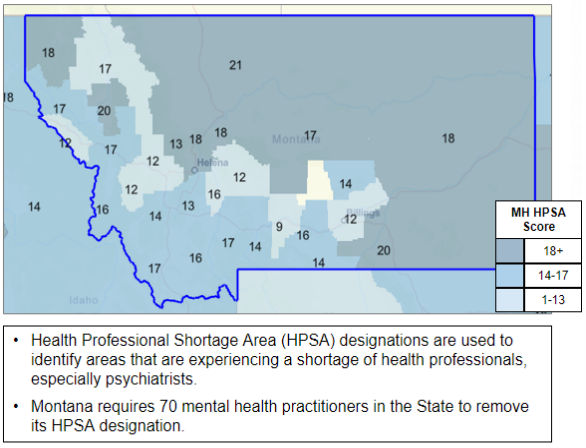


Figure 54. Psychiatry Health Professional Shortage Data[132,133,134]

Comparing Montana's BH workforce supply against Comparison States

Evaluating the BH provider supply in comparison states, states with similar geography and demographics and top ranked states for behavioral healthcare, allowed the study team to compare those states' provider supply and care models to the current landscape in Montana. The study team evaluated opportunities to enhance Montana's future state design of the care model based on the findings of this comparative analysis. Due to limited data on the number of behavioral healthcare setting types in each comparison state, ***the study team leveraged data***

[132] "Map of Health Professional Shortage Areas: Mental Health, by County, 2023 - Rural Health Information Hub," 2023, https://www.ruralhealthinfo.org/charts/7.

[133] Montana Healthcare Foundation, "Integrated Behavioral Health - Montana Healthcare Foundation," January 18, 2024, https://mthcf.org/priority/integrated-behavioral-health/.

[134] "Mental Health and Substance Use State Fact Sheets | KFF," KFF, March 20, 2023, https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/.

from SAMHSA's directory of State MH and SUD agencies to use as a representative sample (proxy) to compare availability of behavioral healthcare settings in Montana versus comparison states.

A comparison of Montana's BH workforce data, shown in Table 39, shows that Montana ranks 45th for psychiatric providers, 35th for psychologists, and 8th for other BH professionals versus comparison states for BH provider availability relative to population. The data suggest that Montana relies on social workers (SW), counselors, and therapists to support behavioral healthcare needs as evidenced by a higher ratio of these healthcare professionals compared to comparison states. Factors such as challenges to accessing services, case management, and care coordination impact Montana's lower BH rankings. The data indicates that workforce shortages may be correlated with Montana's lower assessment on BH rankings.

Shortages of psychiatric providers and psychologists make the feasibility of scaling clinical models / service lines within new sub-acute care settings difficult and limit the movement of individuals from acute institutions to the lowest acuity care settings that can effectively address their needs.

Providers, particularly psychiatrists and psychologists, are essential in the delivery of more advanced care in community-based settings. As shown in Table 39 and Table 40, Montana has a much lower supply of psychiatrists and psychologists when compared to peer states.

Table 39. Overall State Ranking of BH Provider Supply per 100,000 Persons[135]

Ranks	MT	WI	ND	SD	WY	IA	WA	MA
BH Overall Rank	31	1	21	37	45	20	32	3
Psychiatric*	45	22	15	34	48	35	30	1
Psychologists*	35	26	25	43	18	34	27	2
SWs/Counselors/Therapists	8	29	19	32	11	38	30	4

Highest Rank	1st	2nd	3rd	4th	5th	6th	7th	8th	*Lowest Rank*

Table 40. BH Workforce Supply per 100,000 Persons by State[136]

BH Provider Types	MT	WI	ND	SD	WY	IA	WA	MA
Psychiatric Physicians*	9.1	14.5	15.7	12.4	7.2	11.6	13.1	37.6
Psychologists*	26.5	34.2	34.5	18.7	41.2	27.3	33.8	88.8
SWs/Counselors/Therapists	284.0	180.0	207.8	165.4	269.4	141.3	174.0	353.0

[135] "Behavioral Health Workforce Tracker."

[136] *Ibid*

Table 41. Average Psychiatric Providers per Location by State[137,138,]

Average Psychiatric Providers per Location				
Behavioral Healthcare Settings	**MT**	**ND**	**SD**	**WI**
Inpatient	10.1	15.7	8.3	14.5
Partial Hospitalization	8.3	6.3	20.7	20.7
Residential	3.3	4.9	5.2	24.2
OP SUD	0.9	2.2	1.9	3.3
OP MHC	3.4	8.3	5.2	5.2
Intensive OP	2.3	4.4	4.1	13.2
Multi-Setting	15.2	52.5		145.2

Lowest Highest

Table 42. Average Psychologists per Location by State[139,140]

Average Psychologists per Location				
Behavioral Healthcare Settings	**MT**	**ND**	**SD**	**WI**
Inpatient	29.4	34.5	12.5	34.2
Partial Hospitalization	24.1	13.8	31.2	48.8
Residential	9.4	10.8	7.8	57.0
OP SUD	2.5	4.9	2.9	7.8
OP MHC	9.8	18.2	7.8	12.2
Intensive OP	6.6	9.6	6.2	31.1
Multi-Setting	44.1	115.1		341.9

Lowest Highest

Table Note: Values in the tables above were calculated by dividing the number of providers in each state (data from GWU university) by the number of state MH agencies reported in SAMHSA's National Directory of Mental Health and Substance Use Facilities. The study team leveraged data from SAMHSA's directory of State MH and SUD agencies to use as a representative sample to compare availability of behavioral healthcare settings in Montana versus comparison states. These are color coded from highest (green) to lowest value (red). Inpatient refers to psychiatric hospitals listed in the directory. Data on IBH workforce for comparison states is limited and therefore is not shown. Site counts are based on count of unique addresses in SAMHSA's directory. A site may be represented across multiple care settings if it offers relevant services for the category. Blank cells represent that no data was available.

[137] *Ibid.*

[138] List of State Mental Health Agencies from SAMHSA National Directory of Mental Health (MH) and Substance Use (SU) Facilities (2023)

[139] "Behavioral Health Workforce Tracker."

[140] List of State Mental Health Agencies from SAMHSA National Directory of Mental Health (MH) and Substance Use (SU) Facilities (2023)

Evaluating Montana's Supply of BH Providers

Performing an assessment of the availability of BH providers in Montana's regions assisted the study team in understanding the relative magnitude of BH workforce shortages, highlighting the areas and communities with the most pressing challenges. Table 43 supports the points below:

- Montana's regions, especially 1 and 2, have an **insufficient BH workforce and lack of psychiatrists and psychologists.** Regions 1, 2, and 3 often have the lowest BH provider supply rates relative to their population. Residents of Region 1 are more likely to travel longer distances to see behavioral healthcare providers.
- **Social workers, counselors, and therapists** play a key role in BH service delivery as they are **more readily available than other provider types in Montana.** Compared to other regions in the State, Regions 1 and 2 still have much lower ratios of social workers, counselors, and therapists to support behavioral healthcare.

These findings suggest that increasing the provider supply to support existing and additional care settings proposed, especially for sub-acute settings, can support an enhanced BH system.

To date, DPHHS has worked to increase access to BH services through telehealth and ancillary BH workers (e.g., peer support specialists and community health workers). Further optimizing the reach of these efforts could involve providing 24/7 access to telehealth support through a contracted after-hours agency. Additionally, access to trained telehealth providers that are connected via tablets to police stations, clergy, school nurses/social workers could strengthen the BH system by serving as an on-the-ground connectivity resource. BH training programs to enhance the skills and capacity of ancillary BH workers to address behavioral healthcare needs could also be impactful, especially in regions with greater BH workforce shortages.

Table 43. 2023 BH Workforce Supply per 100,000 Persons per Region

BH Provider Types	Region 1	Region 2	Region 3	Region 4	Region 5	statewide
Psychiatric Providers	1.3	6.6	14.5	16.4	11.7	12.2
Psychologists	5.2	14.5	11.9	15.5	26.0	17.2
SWs/Counselors/Therapists	62.8	120.0	167.5	193.6	223.0	178.2
Total	**70.7**	**142.4**	**199.7**	**228.4**	**263.9**	**210.8**
Total Supply	54	216	453	709	903	2,335
% of MT Supply	2.3%	9.3%	19.4%	30.4%	38.7%	100.0%
Population (2022)	76K	152K	227K	310K	342K	1.1M
% of MT Population	6.9%	13.7%	20.5%	28.0%	30.9%	100.0%

Table Note: Data is from the Definitive Healthcare list of BH providers in Montana, providers listed in the Medicaid MMIS claims data set (2018-2023), and ESRI Population Data (2022). Values in the table show the ration of the BH provider types per 100,000 population in each region, based on data gathered from BH Medicaid claims data and Definitive Healthcare. The SWs/Counselors/Therapist classification data includes Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Addiction Counselors (LACs), Behavior Analysts, Licensed Marriage and Family Therapists. BH workforce supply in this table is not all inclusive due to data limitations. Though not included, Advanced Practitioners (Nurse Practitioners and Physician Assistants) and certified peer specialists play a significant role in behavioral healthcare delivery and are an integral part of the BH workforce.

Assessing the Availability of BH Workforce Relative to Access Points in Montana

Measuring average supply of psychiatric providers and psychologists across care settings in the regions highlights workforce gaps that must be addressed to implement recommendations. Taking together provider shortages and gaps in care site locations, a relative view of capacity at existing behavioral healthcare sites was developed. The study team did not have care site visit volume (e.g., capacity) or the number of providers at each care site. As such, the study team calculated proxy capacity by dividing the number of BH providers in the region by number of behavioral healthcare sites in each region. It must be noted that each BH provider type does not necessarily practice in each of the behavioral healthcare sites. The calculation allowed the study team to understand relative capacity and care setting types by region. Importantly, this analysis enabled the study team to identify relative access and capacity differences across Montana's regions. Table 44, Table 45, and Table 46 show major staffing deficits, especially in Regions 1 and 2, which have the lowest provider ratios across all care settings. The data analysis showed:

- There are **less BH providers than expected relative to the number of behavioral healthcare sites in certain regions of the State**, resulting in care sites having limited ability to serve the needs of residents. This was echoed in feedback from Subcommittees and stakeholders.
- **Regions 1 and 2 do not have enough BH providers to support current sites** where residents seek care and/or services.
- **Even Regions 4 and 5 that have a higher measurable supply** of psychiatric providers and psychologists, **show limited number of providers** to support care needs in their respective areas, as evidenced by low average providers per location.
- **Montana relies** on a cadre of **social workers, counselors, and therapists specializing in behavioral healthcare to address the needs of residents**, which may be due to greater availability of training institutions for these providers.

Table 44. Average Psychiatric Providers per Location by Region

Behavioral Healthcare Settings	Region 1	Region 2	Region 3	Region 4	Region 5
IP (All)	0.08	0.7	2.5	3.2	2.7
Crisis Services		10.0	16.4	17.0	5.7
Partial Hospitalization		5.0	11.0	25.4	10.0
Intensive OP	0.25	1.0	2.7	3.4	3.1
Residential Facility	0.17	0.7	1.5	1.3	0.8
OP MHC	0.04	0.4	0.9	0.9	0.7
OP SUD	0.03	0.2	0.9	1.0	0.6
Multi-Setting	0.50	10.0	16.4	50.9	40.0

Table Note: Data used is from Definitive Healthcare list of BH providers in Montana, and providers listed in the Medicaid MMIS claims data set (2018-2023). Locations are from SAMHSA's National Directory of Mental Health (MH) and Substance Use, DPHHS website/personnel (list of mental health agencies, Bounds list of care sites, and I/DD Type 82 providers), Medicare Compare (hospitals and nursing homes), ESRI (2022 population) and Claritas (Montana population density and land mass). IBH care settings are not included due to limited information on number of providers available of Montana's IBH sites.

Table 45. Average Psychologists per Location by Region [141]

Behavioral Healthcare Settings	Region 1	Region 2	Region 3	Region 4	Region 5
IP (All)	0.33	1.6	2.1	3.0	5.9
Crisis Services		22.0	13.5	16.0	12.7
Partial Hospitalization		11.0	9.0	24.1	22.2
Intensive OP	0.99	2.2	2.2	3.2	6.8
Residential Facility	0.66	1.6	1.2	1.3	1.8
OP MHC	0.16	0.8	0.7	0.9	1.5
OP SUD	0.11	0.5	0.7	1.0	1.4
Multi-Setting	1.99	22.0	13.5	48.1	89.0

Table 46. Average SWs/Counselors/Therapists per Location by Region[142]

Behavioral Healthcare Settings	Region 1	Region 2	Region 3	Region 4	Region 5
IP (All)	4	13	29	38	51
Crisis Services		182	190	200	109
Partial Hospitalization		91	127	300	191
Intensive OP	12	18	32	40	59
Residential Facility	8	13	17	16	15
OP MHC	2	7	11	11	13
OP SUD	1	4	10	12	12
Multi-Setting	24	182	190	601	763

The study team mapped the locations of BH psychiatrists and psychologists and other BH professionals (social workers, counselors, and therapists) by region to understand the distribution of BH providers across the State. Findings include:

- There is a **higher concentration of BH providers in the western part** of the State (Regions 4 and 5), **where the population density is higher**.
- **Providers tend to provide care in the densest areas** of each region, leaving **many communities without ready access to psychiatrists and psychologists** and other behavioral healthcare providers.
- **Regions 1 and 2 have the smallest supply of BH workforce** and their **residents are more likely to travel long distances** to see BH providers than residents of Region 5 or 4, as shown in Figure 55 and Figure 56.
- **Even in more population dense regions** like 4 and 5, there are **substantial portions of the regions that do not have access to psychiatrists and psychologists**; residents in those areas must also travel farther for behavioral healthcare.

[141] *Ibid.*

[142] *Ibid.*

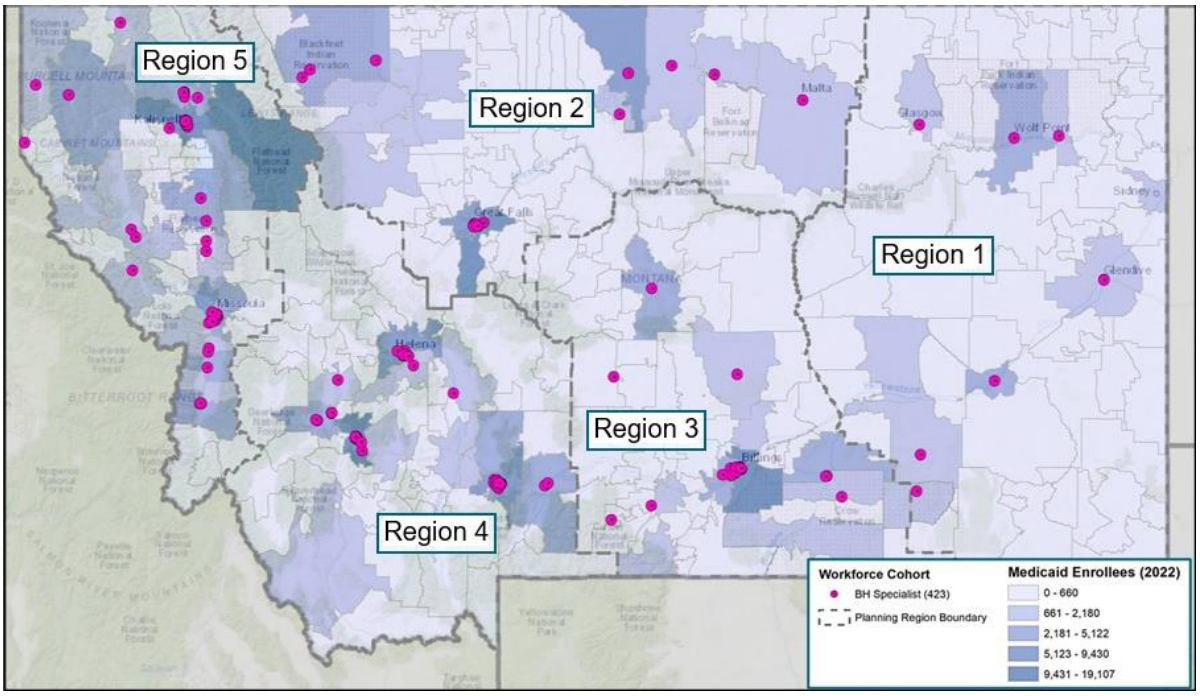


Figure 55. BH Psychiatrists and Psychologists that Accept Medicaid

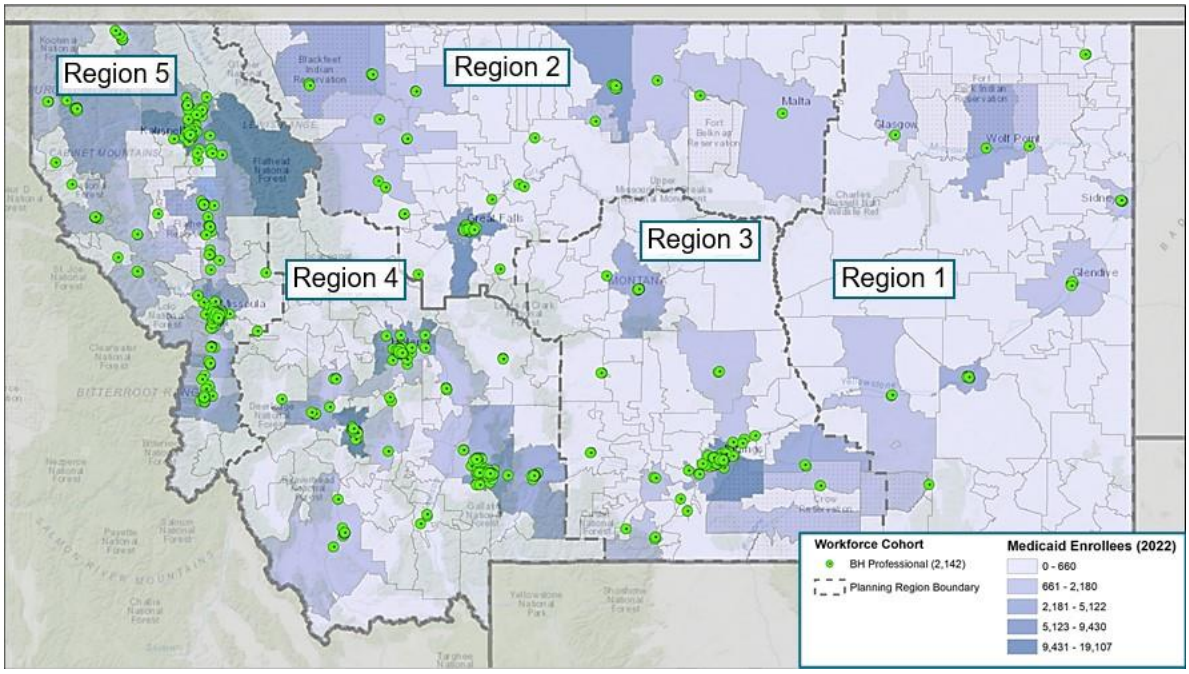


Figure 56. BH Professionals that Accept Medicaid

Insights on BH Workforce Challenges from Medicaid Data

Having sufficient BH providers is essential for the healthy functioning of Montana's BH ecosystem and care continuum. Addressing workforce shortages is crucial to enhancing Montana's behavioral healthcare continuum.

The study team analyzed Medicaid claims data to understand providers' current role in the BH ecosystem. The data shows utilization patterns differences across Montana's regions. The data shown in Figure 57 and Figure 58, below, aligns with feedback heard from stakeholders about the unique challenges faced in serving the needs of each region.

There is significant variation in utilization of BH workforce across the regions, as seen in Figure 57. The differences in BH workforce service delivery (i.e., utilization) across the regions, reflect the unique features of providing care in each region and BH workforce shortages faced by the regions' residents.

Subcommittee feedback indicated that these varied patterns are reflective of residents' access to BH services in each area. The data shows that **Regions 3, 4, and 5 have greater access to various behavioral healthcare settings and providers and as such, have higher provider utilization rates than Regions 1 and 2** (see Figure 57 and Figure 58).

Figure 57 shows that Region 2 has low utilization of psychiatric providers and psychologists relative to the population, especially when compared to rates in other regions. Subcommittee members and stakeholders discussed factors that drove utilization rates in Region 2 but were unsure of the root cause.

Figure 57 also shows that Region 1 has some of the lowest BH provider utilization rates for Medicaid enrollees, indicating an access or service gap, resulting in unmet care needs for residents in those regions. It is possible that the lack of psychiatric providers in Region 1 shown in Figure 57 and Figure 58 could be driving higher utilization of psychologists. Region 1 leverages other BH providers and non-BH providers to mitigate BH psychiatrist and psychologist provider shortages, as evidenced by higher utilization rates for mid-level providers, behavior analysts, and non-psych providers seen in Figure 57.

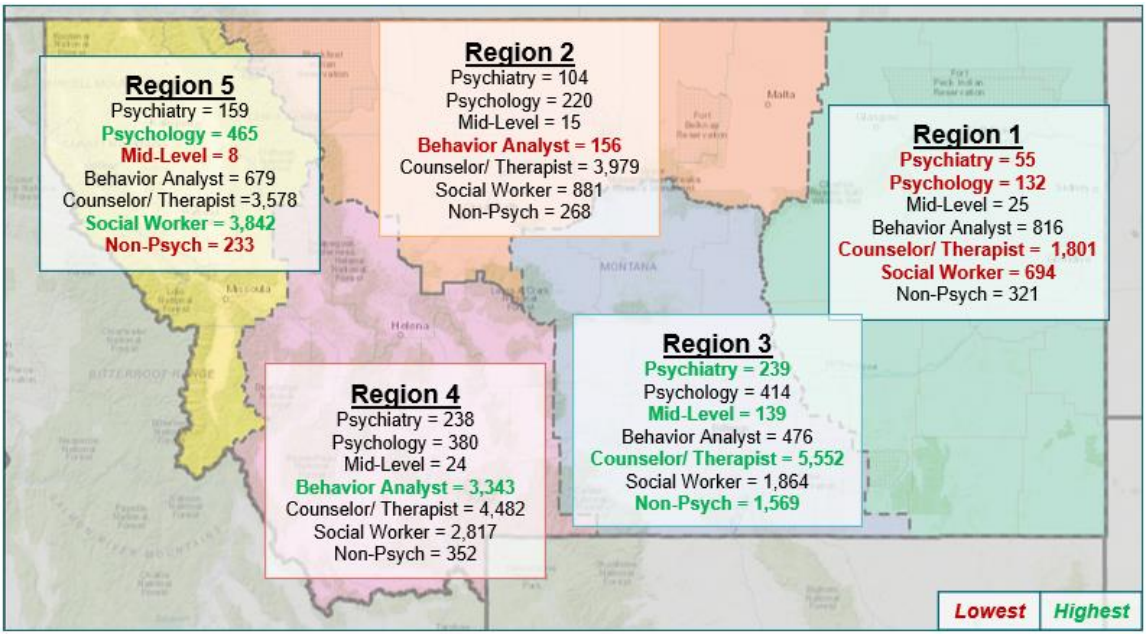


Figure 57. 2022 BH Provider Claims per1,000 Medicaid Enrollees by Region[143]

Figure Note: Data source is Medicaid MMIS professional billing claim data for enrollees with a BH or I/DD diagnosis in CY 2022 who visited a provider for a BH related reason. Utilization per 1,000 Medicaid enrollees reflects total billed quantity of professional billing claims per 1,000 enrollees. In this context, specialists refer to psychiatrists and psychologists. Consults Medicaid professional billing total billed quantity.

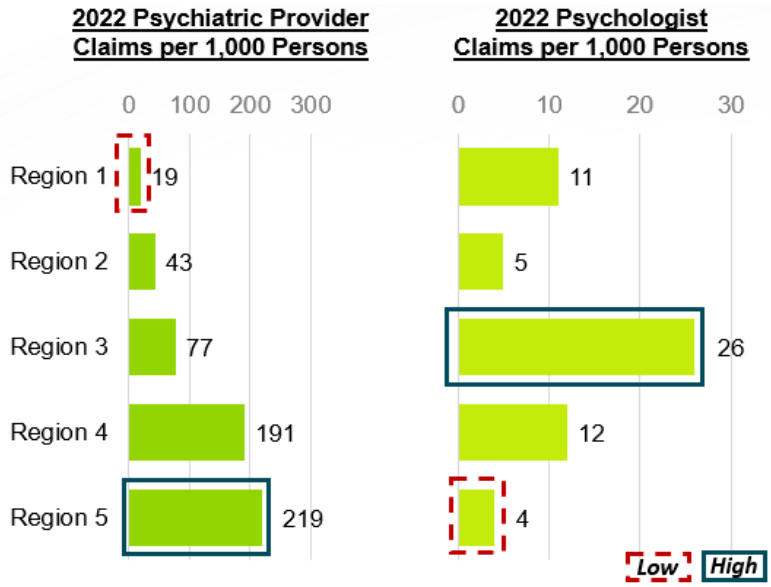


Figure 58. Psychiatric Provider & Psychologists Medicaid Claims per 1,000 Medicaid Enrollees[144]

Figure Note: Claims are billed quantity in professional billing data set. Claims per 1,000 are claims per 1,000 Medicaid enrollees.

[143] MMIS Medicaid claims data

[144] MMIS Medicaid claims data, Clarivate payer enrollment data (2022).

Montana BH Workforce Environment - Key Findings

Below is a list summarizing the key findings regarding Montana's BH workforce environment.

Figure 59. Montana BH Workforce Environment - Key Findings

Continuum of Care

Montana's BH Infrastructure

Evaluation of access to care settings and workforce that serves the BH population highlight gaps contributing to Montana's BH ecosystem challenges. However, challenges observed are not limited to those two domains. Fragmentation of the care continuum is also a key driving factor behind the outlined BH prevalence outcomes and service access challenges. Numerous organizations, providers, and programs currently contribute to Montana's behavioral healthcare continuum.

While these services are grouped by functionality or service focus (see Figure 60), the **service organizations lack intra-organizational communication and coordination**. The result is multiple entities **working towards the care of one individual or one larger cause in a potentially inefficient, costly, and ineffective manner**. Care fragmentation can lead to poor communication and coordination among providers, which is associated with increased ED and hospital use, resulting in increased cost.

Figure 60 depicts the current behavioral healthcare continuum in Montana, with limited coordination, intentional hand-offs, or formalized integration mechanisms. Of note, Figure 60 is not a comprehensive illustration of all services in Montana, but instead includes major areas of service provision, categorized by type, for a general understanding of major contributors by sector.

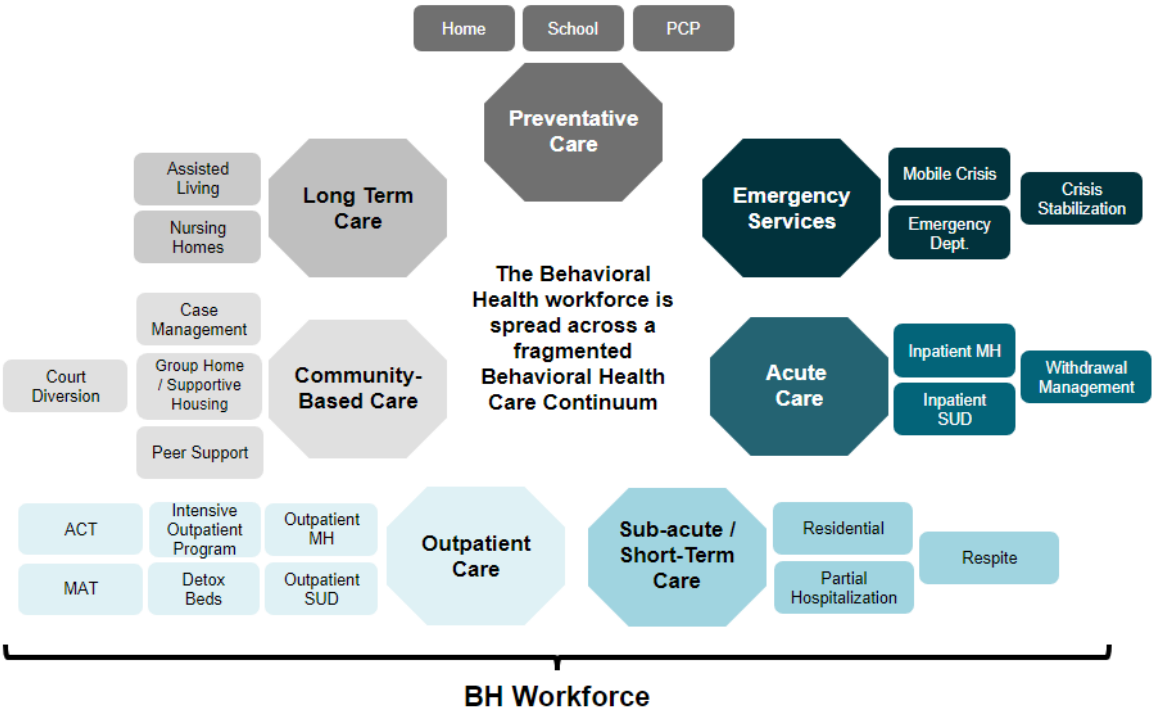


Figure 60. Fragmentation of Montana's BH Continuum

Figure Note: Respite care refers to short-term, relief care services for primary caregivers of adults or pediatrics.

Key Themes Shaping the Current State of BH Services

The delivery system of BH in Montana is complex, reflecting the State's widespread and diverse geography. Traveling the State to access care is challenging for various populations based on the long winter season and the State's topography, which requires travel routes that bypass mountain ranges. From persistent workforce shortages to uneven access across regions, the State has obstacles impacting individuals seeking care. Listening sessions highlighted system access challenges with various groups. In Table 47, the study team explored the key themes that stakeholders voiced as shaping the current state of BH services.

Table 47. Key Themes Shaping the Current State of BH Services

No.	Theme	Summary
1.	**Coordination Challenges in BH Services**	The lack of care coordination and service alignment significantly limits the efficacy of BH service provision in Montana.
2.	**Gaps in Sub-acute and Transitional Service Provision**	There is a significant vacuum across the State regarding sub-acute and transitional service provision.
3.	**Direct-Care Staff Workforce Limitations**	Workforce limitations persist across the State, in frontier and populated areas alike. Direct-care staff require particular attention and investment.
4.	**Localized Crisis Management and IP Reliance**	Crisis service provision is currently local in nature and the lack of statewide, coordinated crisis management contributes to heavy reliance on IP care.
5.	**Limited-Service Access in Frontier Regions**	Service provision in the frontier regions of the State is limited and will require significant investment and unique approaches to care delivery.
6.	**Placement Challenges for Individuals with Multiple Diagnoses**	Individuals with multiple diagnoses, particularly I/DD and BH diagnoses, have a challenging time finding appropriate placement in Montana that serves all their care needs.
7.	**Unmet BH Needs of the Pediatric Population**	Pediatric BH needs are frequently not met in-state, resulting in placement out-of-state for appropriate clinical care.
8.	**Inadequate Wraparound Services: Transportation and Housing**	Wraparound services, specifically transportation and housing, are inadequate and limit the potential for individuals to have their needs met within their communities.
9.	**Enhancing Peer-Support Services and Ancillary Professional Programs**	Peer-support services and other ancillary professional programs are effective and should receive increased investment and use.
10.	**Telehealth Expansion with Caution for Severe Conditions**	Telehealth should be utilized more frequently to reach more people in need of services but cannot be relied upon as the main solution for OP care, particularly for individuals with specific, moderate-to-severe conditions.

Apart from qualitative research and stakeholder feedback, quantitative analysis reinforced concern about the functionality of Montana's care continuum for BH services at the state level. Montana is higher than peer states for the number of care sites per capita. However, the geographic size of the State hinders some of the efficacy and impact of its quantity of care sites, as clients face significant travel to access BH services. Further examination of access points relative to BH provider supply showed a lower number of providers, particularly specialists, per care setting compared to other states (see Table 48).

Table 48. State BH Locations per 100,000 Persons (2023)[145,146,147]

Behavioral Healthcare Settings	MT	ND	SD	WI
IP	0.9	1.0	1.5	1.0
Partial Hospitalization	1.1	2.5	0.6	0.7
Residential	2.8	3.2	2.4	0.6
OP SUD	10.5	7.0	6.4	4.4
OP MHC	2.7	1.9	2.4	2.8
Intensive OP	4.0	3.6	3.0	1.1
Multi-Setting	0.6	0.3	0.0	0.1

Table Note: Data in the table is from SAMHSA's report listing the number of State MH agencies in each state. The study team leveraged data from SAMHSA's directory of State MH and SUD agencies to use as a representative sample to compare availability of behavioral healthcare settings in Montana versus comparison states. The table shows the average number of state MH agencies in SAMHSA's directory per 100,000 persons who live in the states color coded from highest (green) to lowest value (red). It compares availability of State MH Agencies relative to population across the care setting types for the states displayed. Site counts are based on the count of unique addresses in SAMHSA's database. A site may be represented across multiple care settings if it offers relevant services for the category. Other care settings are not shown due to lack of data.

Montana demonstrates the highest availability of sites per capita across service type, while still maintaining lower performance in prevalence and access in BH outcomes, which suggests there may be a care quality and access issue with the care sites that do exist that could most directly be addressed through enhanced care management and coordination.

The above outcomes and stakeholder concerns regarding care coordination directed data analytics and research on national BH service standards and outside state practices.

To put forth recommendations aligned with the goals of the design study, the study team researched national trends and innovations in state behavioral healthcare delivery. Reviewing best practices, state investments, and academic propositions underscored **six central topics** fundamental to optimizing behavioral healthcare delivery.

1. At the forefront of these investments is a concerted effort to **integrate physical and behavioral healthcare** to reduce cost, improve overall client outcomes, and coordinate care overall.[148,149]
2. Nationally, there is a growing understanding that Medicaid reimbursement drives the behavioral healthcare market, provider availability, and patient choice. **Optimizing Medicaid reimbursement rates** to expand care and increase provider reimbursement

[145] "Behavioral Health Workforce Tracker."

[146] "National Directory of Mental Health Treatment Facilities 2021."

[147] "National Directory of Drug and Alcohol Abuse Treatment Facilities 2022."

[148] Lindsey Browning, "Medicaid Forward: Behavioral Health," National Association of Medicaid Directors (NAMD), March 15, 2021, https://medicaiddirectors.org/resource/medicaid-forward-behavioral-health/.

[149] Mike Nardone, Sherry Snyder, and Julia Paradise, "Integrating Physical and Behavioral Health Care: Promising Medicaid Models | KFF," KFF, February 12, 2014, https://www.kff.org/mental-health/issue-brief/integrating-physical-and-behavioral-health-care-promising-medicaid-models/.

has been an area of focus across the United States.[150,151]

3. With the introduction of the national #988 National Suicide and Crisis Lifeline and expansion of mobile crisis unit programs, states are strengthening their ability to **respond to BH crises in the community** with the goal of preventing avoidable IP care.[152]
4. The utilization of **telehealth services** for OP physical and behavioral healthcare, expanded during the COVID-19 U.S. Public Health Emergency, continues to be utilized in behavioral healthcare to expand provider catchment areas, reach clients in rural/frontier regions, and minimize workforce strain across the field.[153]
5. Concerning national pediatric MH outcome reports have led to several states bolstering attention and investment in **pediatric behavioral healthcare**.[154]
6. **Peer support services**, and other ancillary professional designations, have proved effective in enhancing access to and optimizing effectiveness of the behavioral healthcare system. State programs that support para-professional BH training have become increasingly popular and foundational to care coordination, recovery support, and service provision, particularly in more rural states.[155]

To further support solution development for care coordination challenges, extensive qualitative research continued to consider state models for care oversight and quality improvement. The study team examined state BH initiatives and organization authorities for their programmatic structure for best practices and lessons learned that could aid in addressing key challenges in provision of behavioral healthcare for Montana's ecosystem.

National review of research revealed that managed care models are the primary driving infrastructure of change in Medicaid BH services across the United States. [156,157,158]

[150] Madeline Guth et al., "How Do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs | KFF," KFF, May 25, 2023, https://www.kff.org/mental-health/issue-brief/how-do-states-deliver-administer-and-integrate-behavioral-health-care-findings-from-a-survey-of-state-medicaid-programs/.

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[153] "Telehealth Use in Rural Healthcare Overview - Rural Health Information Hub," n.d., https://www.ruralhealthinfo.org/topics/telehealth.

[154] Imogen Bell et al., "The Impact of COVID-19 on Youth Mental Health: A Mixed Methods Survey," *Psychiatry Research* 321 (March 1, 2023): 115082, https://doi.org/10.1016/j.psychres.2023.115082.

[155] "Peer Support: Research and Reports," Mental Health America, n.d., https://mhanational.org/peer-support-research-and-reports.

[156] Browning, "Medicaid Forward: Behavioral Health."

[157] Guth et al., "How Do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs | KFF."

[158] "National Rural ACO | About Us," n.d., https://www.nationalruralaco.com/practice-transformation.shtml.

Table 49. U.S. BH Medicaid Infrastructure

Managed Care Model	Participating State Total
Managed Care Organization (MCO)	**35 states**
Managed Care Organization (MCO) and Primary Care Case Management (PCCM)	7 states
Primary Care Case Management (PCCM) only	5 states
No comprehensive Medicaid Managed Care (MMC)	5 states

ACO Design and Payment Structure Analysis

Given the unique frontier and low population density of Montana, research considered how strategic care coordination and managed care models are formatted in states with similar characteristics, revealing ACOs in Colorado, Minnesota, and Oregon to be potential models with applicability for Montana, as described in Table 50.[159,160,161,162,163]

Additionally, state research informed programs and behavioral healthcare initiatives that served as examples for innovative practice and progress towards care continuum improvement. Diversifying states considered for their respective policy approaches solidified solutions considered for Montana's ecosystem and informed recommendations made in this report and are described in Table 52.[164,165,166,167,168,169]

[159] Stuart Gordon, "Integrating Behavioral Health into Accountable Care Organizations: Challenges, Successes, and Failures at the Federal and State Levels" (National Association of State Mental Health Program Directors, September 2016).

[160] Neva Kaye, "Three States' Strategies to Improve Behavioral Health Services Delivery through Medicaid Accountable Care Programs" (National Agency for State Health Policy (NASHP), October 23, 2020).

[161] "Accountable Care Collaborative Phase II: Framework for Behavioral Health Reimbursement" (Colorado Department of Health Care Policy & Financing, March 2016).

[162] "Integrated Health Partnerships (HIP)," Minnesota Department of Human Services, October 2, 2023, https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/.

[163] Elizabeth Holder, "Medicaid ACOs Oregon," n.d., https://www.naacos.com/medicaid-acos-oregon.

[164] "Georgia Behavioral Health Reform and Innovation Commission: 2022 Annual Report," *Georgia Office of Health Strategy and Coordination*, 2021, https://www.house.ga.gov/Documents/CommitteeDocuments/2022/Behavioral_Health/Annual_Report_2022_BHRIC_FINAL_Exec_Summary.pdf.

[165] Georgia Department of Community Health, "Medicaid Managed Care," January 11, 2024, https://dch.georgia.gov/medicaid-managed-care.

[166] "Guide: Using Mobile Crisis Services in Lieu of an Order to Apprehend," *George Department of Behavioral Health & Developmental Disabilities*, n.d., https://dbhdd.georgia.gov/mobile-crisis-services#:~:text=24%2F7%20mobile%20response%20provides,%2D800%2D715%2D4225.

[167] "South Dakota Mental Health System Guidebook," Slide show, PsychU, 2017, https://psychu.org/wp-content/uploads/2018/11/PsychU-2018-South-Dakota-Guidebook-1.pdf.

[168] "Department of Social Services," n.d., https://dss.sd.gov/behavioralhealth/services.aspx#:~:text=Appropriate%20Regional%20Facilities%20(ARFs)%20are,be%20stabilized%20closer%20to%20home.

[169] "Behind the Curtain: Mental Health Services for All Stages of Life within the Publicly Funded Behavioral Health System," Slide show, South Dakota Department of Social Services, April 13, 2022, https://dss.sd.gov/docs/behavioralhealth/resources/04.13.22_Slides.pdf.

Table 50. Colorado, Minnesota, and Oregon ACO Design and Payment Structure Analysis

State	Inception	ACO Design	Payment Structure	Impact
Colorado	Began in 2011; behavioral healthcare was incorporated in a second phase in **2018**	7 contracted Regional Accountable Entities: • Support a local network of primary care medical providers, • Coordinate members' care across systems, • Hold responsibility for the cost and quality of care delivered.	• Providers are **required to contract** with a RAE to service Medicaid enrollees. • RAEs are paid through a combination of per member per month administrative payments, administrative payments, capitation, and incentive payments.	• **97% of Medicaid enrollees** in Colorado are enrolled in an RAE. • Colorado reports an increase in the number of Medicaid enrollees receiving BH services since 2018.
Minnesota	Began in 2013; behavioral healthcare was incorporated in a second phase in **2018**	26 Integrated Health Partnerships: • Develop and implement specific health initiatives, • Address specific social risk factors, • Meet quality and performance measures.	Integrated Health Partnerships (IHPs) have two payment models: • **Track 1:** Geared for small, independent providers. • **Track 2:** Geared for IHPs with more than 2,000 members.	• As of June 2020, IHPs serve **430,000 individuals.** • Minnesota ACO providers have performed better than other clinics in **screening pediatrics for MH conditions.**
Oregon	Began in **2012** and included coordinating physical, behavioral, and oral healthcare	15 Coordinated Care Organizations: • Improve healthcare delivery, • Lower costs.	Coordinated care organizations receive payment by: • **Quality pool funds** earned through performance. • **Challenge pool funds** received for improvement targets.	• By mid-2015, Oregon had **reduced ED utilization by 23%** through its CCO initiative.

Table 51. Alaska and North Dakota: Alternative Care Coordination Strategic Models

State	Inception	Program	Impact and Considerations
Alaska	In 2016, SB 74 passed to **improve the effectiveness, efficiency, and integration** of Alaska's BH system. Two key activities came of SB 74: • The **Alaska 1115 Demonstration Waiver Project.** • Implementation of **Administrative Service Organizations (ASO)** to coordinate the statewide BH system redesign.	Alaska's ASOs are charged to: • **Increase access** to BH services, • **Improve outcomes** for clients **regardless of payer type,** • **Reduce overall cost of services.**	**Optum** was hired to serve as the **ASO** under state authority: • During **years one and two**, providers reported **significant issues,** including poor communication, unclear guidelines, and billing issues. • Providers found the transition **overwhelming.** Alaska's Department of Health reports the full potential of the ASO model has not been realized.
North Dakota	In 2018, a systematic review of North Dakota's BH system reported a statewide need for **bolstering of rehabilitative and community-based services** in lieu of an over-emphasis on acute and crisis BH services. • As part of recommendations of the review, North Dakota Department of Health created **Community Connect**.	North Dakota's Community Connect: • Aims to **expand quality, community based BH services.** • Creates specific **focus, training, and funding** for care coordinators, peer support services, and rehabilitation services. • Allows for **private providers** or **non-traditional providers**, such as faith-based or cultural-specific group leaders.	Care coordinators: • Complete **state-approved training** • Serve as a source of **cross-sectional partnership and collaboration with private and public providers.** • Are **accountable** for an individual's overall care and services received, meeting with an individual monthly and maintaining a care plan. • A full-time care coordinator can **serve 20-25 individuals**, and are reimbursed on a state-run, tiered system based on services provided to everyone they serve monthly.

Table Note: Several states in the United States do not utilize manage care models for state-level system coordination and/or quality improvement of BH services. Instead, Alaska and North Dakota apply other alignment models to focus on improving their behavioral healthcare continuum at large.[170,171,172,173]

[170] Gennifer Moreau and Farina Brown, "Medicaid Section 1115 Behavioral Health Waiver Demonstration Project," Slide show, Alaska Department of Health and Social Services, October 30, 2019, https://alaskamentalhealthtrust.org/wp-content/uploads/2018/07/HandOut-Medicaid-Waiver-1115-Update-Presentation-Nov2019.pdf.

[171] "The Alaska Substance Use Disorder Treatment and Behavioral Health Program 1115 Waiver Extension Request," *Alaska Department of Health*, 2022, https://health.alaska.gov/dbh/Documents/1115/1115_Waiver_RenewalApplication.pdf.

[172] "Community Connect," Health and Human Services North Dakota, n.d., https://www.hhs.nd.gov/behavioral-health/community-connect.

[173] "Providing Services," Health and Human Services North Dakota, n.d., https://www.hhs.nd.gov/behavioral-health/community-connect/training-resources.

Table 52. Innovative Practices for Continuum of Care Improvement

<table>
<tr><th>State</th><th>Notable Elements of BH System Framework</th><th>Innovations & Notable Activities</th></tr>
<tr><td>Georgia</td><td>

Georgia is not a Medicaid expansion state.
Four Care Management Organizations (CMOs) administer Medicaid reimbursement for BH services:

<table>
<tr><th>Program</th><th>October 2023 Enrollees</th></tr>
<tr><td>Medicaid CMO</td><td>1,972,979</td></tr>
<tr><td>Medicaid FFS</td><td>663,490</td></tr>
<tr><td>Medicaid Total Enrollment</td><td>2,606,469</td></tr>
<tr><td>PeachCare for Kids®</td><td>205,397</td></tr>
</table>
Georgia has an exemplar crisis system, often acknowledged for:
1) A statewide 24/7/365 crisis line that operates based on a clinical triage model.
2) A bed registry established in 2012, integrated with the crisis system.
3) Mobile crisis teams partnered with law enforcement
</td><td>Georgia HB 514 established the Georgia Behavioral Health Reform and Innovation Commission to conduct comprehensive review of the behavioral healthcare system through June 30, 2025:
In 2022, Georgia’s commission had seven core areas of focus:
1) Address the BH workforce shortage,
2) Promote data collection and information sharing,
3) Build a robust crisis system with the full continuum of services,
4) Build capacity within Medicaid,
5) Expand successful community-based practices, services, and programs,
6) Study practices, services, and programs that need improvement,
7) Streamline existing policies and statues.
</td></tr>
<tr><td>South Dakota</td><td>South Dakota finances the majority of Medicaid reimbursed BH services via a fee-for-service (FFS) model.

An exception occurs for individuals with disabilities, who are enrolled in the managed care program.
Since many SMI individuals are dual eligible, their payment source is estimated to be split evenly between FFS and managed care reimbursement.

The Department of Social Services, Division of Behavioral Health contracts with 11 regional community mental health centers and 40 provider organizations for SUD services.</td><td>

South Dakota utilizes a combination of mobile crisis teams and virtual crisis response support to provide crisis response services in both populated and frontier areas of the state.
Systems of Care is a care coordination service provided by South Dakota specifically for pediatric and families with complex care needs, with 600 families served by 44 care coordinators in 33 counties in FY21.
Through multiple state bills and funding allocation between 2020-2023, South Dakota has put significant investment and focus on appropriate regional facilities, intended to provide 24/7 overnight, residential services to stabilize acute psychiatric needs for an individual to stabilize closer to home.

</td></tr>
</table>

Montana BH Continuum of Care Needs - Key Findings

Below is a summary list of the key findings for Montana's BH continuum of care needs.

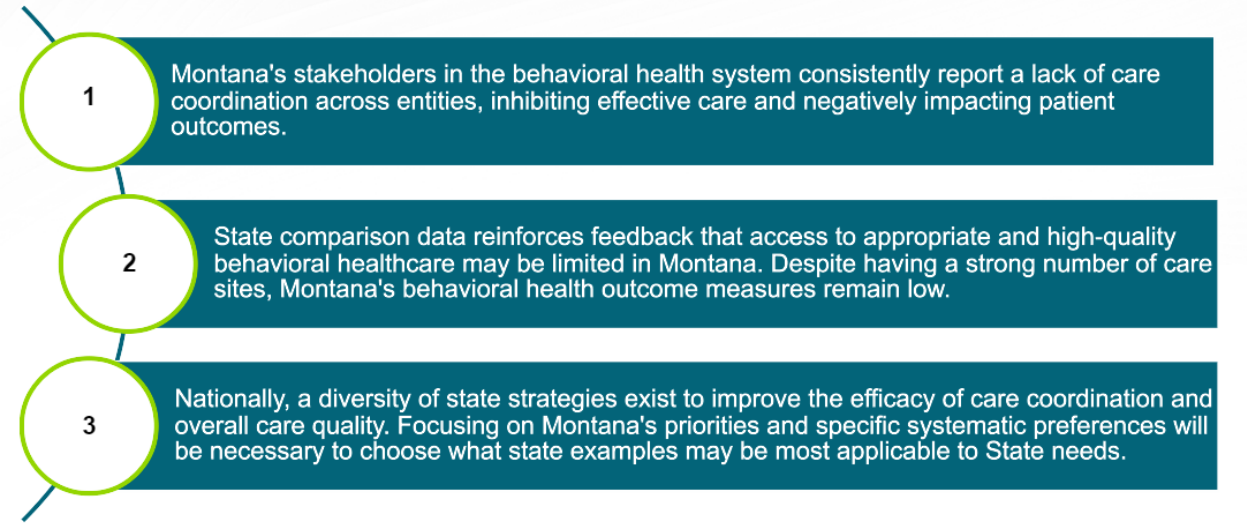


Figure 61. Montana BH Continuum of Care - Key Findings

Data Analysis Key Findings Summary

The extensive and systematic analysis of information and data outlined under the four sections in this appendix helped the study team to develop a comprehensive overview of the current state of Montana's behavioral healthcare ecosystem, especially its challenges. The key findings generated from the data and information analysis informed the study team's recommendations to plan for a more effective BH ecosystem in Montana.

BH Service Needs:

- Montana is predominantly a frontier state, with a few population centers mainly located in the western part of the State. The frontier geography can significantly hinder access to BH services.
- Montana is unique among the states, in that 6.2% of the population is Native American, with multiple Tribal communities in the State; cultural distinctions which must be factored into BH service design.
- Montana has a high burden of BH conditions compared to peer state populations. Montana has the third highest rate of suicide nationally, with high prevalence of SUD and pediatrics with BH diagnoses.
- Overall, population health outcomes, BH standards, and state comparisons suggest Montanans carry a heavy BH condition burden, with limited access to necessary services.

Access:

- Montana may have more state behavioral healthcare sites relative to population size, but it has fewer providers available to support provision of care in those settings.
- Data analysis shows that residents prefer to seek behavioral healthcare close to home, but behavioral healthcare settings are more likely to be in places with high population density. This has resulted in people in more urban settings having more immediate access to care compared to lower population density areas in the eastern, northern, and central parts of the state.
- Regions 1 and 2 do not have the full range of behavioral healthcare settings available within reasonable proximity.
- Regional variations in care setting utilization highlights disparities in access to BH services.

Workforce:

- All regions exhibit scarcity of BH specialists to staff current care locations. Lack of psychiatrists and psychologists is a key factor in challenges observed in Montana's BH ecosystem.
- Lower ratio of BH workforce per behavioral healthcare site, particularly in the eastern and northern regions, results in limited ability to serve the needs of residents.
- Future facility planning must consider the reality of workforce shortages on proposed solutions to mitigate care gaps in the regions.

Care Continuum:

- Montana's stakeholders in the BH system consistently report a lack of care coordination across entities, inhibiting effective care and negatively impacting patient outcomes.
- State comparison data reinforces feedback that access to appropriate and high-quality behavioral healthcare may be limited in Montana. Despite having a high number of care sites, Montana's BH outcome measures remain low.

Nationally, diverse state strategies exist to improve the efficacy of care coordination and overall care quality. Focusing on Montana's priorities and specific systematic preferences will be necessary to choose what state models may be most applicable to addressing the State's needs.

Table 53 denotes the key research findings for each of the five health planning regions that drove the study's geographic organization.

Table 53. Mental Health and SUD Key Findings by Region

Region 1	Region 2	Region 3	Region 4	Region 5
• No **IP psychiatric beds** in-region. • Providing acute and sub-acute services **may be challenging** due to low BH service utilization. • Has **some of the lowest** Medicaid enrollee provider utilization rates, indicating a service gap that could result in unmet care. • **Most Integrated BH (IBH) sites** per 100,000 persons, mitigating impact of limited access to other BH providers.	• Has the **highest share** of Tribal population. • **Second lowest number of IP psych beds** statewide. • **Gaps in access** to residential SUD and MH services for Medicaid enrollees.	• Northern part of the region has **fewer sub-acute access points** for Medicaid enrollees. • Has **highest use** of Advanced Practice Providers, counselors / therapists, and non-psychiatric providers per Medicaid enrollees. • Has the **lowest number of IBH sites** per 100,000 persons under MT Healthcare Foundation's IBH initiative.	• **Disproportionately high- hare of psych beds** due to location of MSH. • Has the **second highest** need for psychiatric beds required to support Medicaid enrollees. • **Gap in MH residential services** for Medicaid enrollees in the southern part of the region.	• Has the **highest** psychiatric bed demand for both adults and pediatrics. • Compared to other regions, has **low residential bed availability** for adults. • Often has **higher density of care settings** and higher ratio of providers than other regions.

Appendix C. Feedback Themes and Planning Implications

Overview of Key Feedback Themes

As part of the exploratory assessment process, the study team conducted a series of interviews with DPHHS staff, subject matter experts, those with lived experience, and Tribal representatives to discuss current state, challenges, and areas of opportunity to improve the BH system in the State.

Appendix B includes a summary of key themes identified by the study team during the interview process. “Key themes” are defined as reoccurring topics or items, mentioned by multiple interviewees, representing areas of strength and opportunities to improve BH and I/DD care. Identified themes within this report serve as a foundation for presented recommendations.

Interview Methodology

The interview methodology employed in the Alternative Settings study centered around conducting comprehensive listening sessions with key stakeholders, specifically targeting leadership within DPHHS, individuals with lived experience, and Tribal leadership. The overarching objective was to gain diverse insights into the BH system, highlighting current challenges and opportunities.

To gain a representative sample, DPHHS leadership selected participants, encompassing executives, directors, and decision-makers, individuals with lived experience sourced through support organizations, and Tribal leadership. The recruitment process involved formal invitations, detailing the voluntary nature of participation, with informed consent emphasizing confidentiality and the research-oriented use of findings.

Data collection relied on semi-structured interviews and participatory listening sessions, guided by a predefined set of questions tailored to each participant group. Interviews with DPHHS leadership focused on organizational strategies and challenges, while lived experience individuals shared personal insights and recommendations. Tribal leadership provided perspectives on cultural considerations and collaborative opportunities.

Facilitators, trained in active listening and unbiased inquiry, led the sessions, and encouraged open dialogue. Review of notes involved thematic analysis, with a focus on identifying recurring themes across interviews and their incorporation into the development of recommendations.

The resulting findings are presented in such a way to respect participant anonymity and confidentiality. The insights gained from these listening sessions serve as a foundation for subsequent workflow analysis and improvement strategies within the DPHHS BH and I/DD system.

Listening Session Details

Table 54. State Govt. Official Listening Sessions

Montana State Government Officials Listening Sessions				
Number of Meetings	**Meeting Length**	**Modality**	**Participant Volume**	**Number of Meetings**
12 meetings	1 hour	Remote	31 participants	12 meetings

Table 55. External Stakeholder Listening Sessions

Key External Stakeholders Listening Sessions				
Number of Meetings	**Meeting Length**	**Modality**	**Participant Volume**	**Number of Meetings**
4 meetings	1 hour	Remote	4 participants	4 meetings

Key Feedback Themes

Given the State's population distribution and regional demographic and geographic variations, navigating the system can be challenging for Montanans. From persistent workforce shortages to unequal access across regions, the State has obstacles impacting individuals seeking behavioral healthcare. Listening session participants highlighted these challenges. Table 56 outlines the key themes on the current state of BH service delivery in Montana.

Table 56. Listening Sessions Key Themes

#	Theme	Summary
1	**Coordination Challenges in BH Services**	A lack of care coordination and service alignment significantly limits the efficacy of BH service provision in Montana
2	**Gaps in Sub-acute and Transitional Service Provision**	There is a significant absence across the State to sub-acute and transitional services
3	**Workforce Limitations, Focusing on Direct-Care Staff**	Workforce limitations persist across the State, in frontier and populated areas alike. Direct-care staff require particular attention and investment including career advancement opportunities, investment in future workforce development, other incentives and benefits including flexible work schedules, loan reimbursement, day care services (adult and child), etc.
4	**Localized Crisis Management and IP Reliance**	Crisis services is currently managed at the local level. This is contributing to heavy reliance on IP care.
5	**Limited-Service Access in Frontier Regions**	BH service provision in the frontier regions is limited and results in many going without behavioral healthcare or seeking out higher cost-settings to find assistance.
6	**Placement Challenges for Individuals with Multiple Diagnoses**	Individuals with co-occurring conditions, for example I/DD and BH diagnoses, have difficulty finding providers who are willing and trained to be able to meet their behavioral healthcare needs. Some report they are being denied access to care in the community.
7	**Unmet BH Needs of the Pediatric Population**	Pediatric BH needs are often not met in State, resulting in placement out-of-state for appropriate clinical care
8	**Inadequate Wraparound Services: Transportation and Housing**	Wraparound services, specifically transportation and housing, are inadequate and limit the potential for individuals to have their needs met within their communities
9	**Enhancing Peer-Support Services and Ancillary Professional Programs**	Peer-support services and other ancillary professional programs are effective and should receive increased use and investment.
10	**Telehealth Expansion with Caution for Severe Conditions**	Telehealth is a service option to offer people choice and expand access. It cannot be relied upon as the main solution for OP care, particularly for individuals with specific, moderate-to-severe conditions

The feedback from stakeholders and participants in interviews informed the 10 key themes above. To provide further context for the themes and resulting priorities, which support study recommendations, please see the information below. The section is a combination of information provided by the stakeholders engaged throughout the Alternative Settings project study and the study team's expansion on stakeholder's thoughts based on subject matter expertise, best practices and lessons learned to address current challenges experienced in Montana's ecosystem.

1. Coordination Challenges in BH Services

Per interviewees, Montana's BH services suffer from fragmentation, causing issues like disjointed care, limited access, and inefficiencies. To address this, interviewees proposed a paradigm shift to integrated care, emphasizing collaborative plans, information sharing, workforce development, telehealth, and client engagement for a more effective system.

Stakeholders reported that delivery of BH services across the State is challenging to navigate due to a lack of coordination and alignment. This fragmentation significantly hinders the efficacy of behavioral healthcare, leaving individuals with unmet needs. The current system is disjointed, with BH services, developmental disability supports, and primary care providers operating in silos, disconnected from each other.

The consequences of this fragmentation are numerous and far-reaching. Stakeholders cited the following observations:

- **Disjointed care:** Clients navigating the system often encounter duplicative assessments, inconsistent treatment plans, and fragmented medication management. This lack of continuity disrupts progress and undermines treatment effectiveness.
- **Limited access:** Fragmented service structure hinder access to care, particularly in rural/frontier areas. Individuals struggle to find providers with the necessary expertise or face significant travel burdens to reach them.
- **Inefficiencies:** The siloed structure leads to redundancies in service provision, driving up costs and diminishing the overall value of the healthcare system.
- **Negative impacts on individuals:** Fragmentation contributes to poorer health outcomes, increased risk of hospitalization, and reduced quality of life for individuals with BH needs and intellectual/developmental disabilities. This inhibits trauma-informed care which further dis-empowers individuals on their recovery journey.

To address these challenges, interviewees indicated a need to shift the care delivery paradigm towards integrated care. This shift involves moving beyond isolated service delivery and creating a system where different disciplines work together seamlessly. Key elements of an integrated care system would include:

- **Collaborative care plans:** Developing comprehensive care plans that holistically address all aspects of an individual's needs, drawing upon the expertise of different providers.
- **Information sharing:** Implementing data-sharing platforms to promote seamless communication and transparency between providers and improving continuity of care.
- **Workforce development:** Investing in training and recruitment initiatives to attract and retain a skilled workforce capable of delivering integrated care.
- **Telehealth expansion:** Leveraging telehealth to overcome geographical barriers and improve access to services in rural/frontier areas, as well as offer choice.
- **Client engagement:** Actively involving individuals and their families through person-centered practices in all aspects of care including decision-making processes, ensuring their voices are heard and their needs are addressed.

Integrated care, while not without its own challenges, offers a promising approach to delivering effective and efficient BH services in Montana. By fostering collaboration and breaking down silos, the State can create a system that better supports Montanans.

2. Gaps in Sub-Acute and Intermediary Service Provision

Per interviewees, Montana faces a crucial gap in subacute and intermediary services for BH and I/DD needs, resulting in disjointed transitions between care settings and limited options. To address this gap, strategic investments, workforce development, system integration, and data-driven decision-making could address these issues and create a robust support system for recovery and empowerment.

Stakeholders observed a void across Montana in the provision of crucial subacute and intermediary care settings for services for individuals with BH needs and/or diagnosed with an I/DD. The gaps in access to appropriate level of care creates barriers to accessing care.

Per interviewees, the current system for BH and I/DD demonstrates stark limitations:

- **Disjointed Transitions:** Individuals exiting IP settings like hospitals lack adequate intermediate- level support options, increasing the risk of readmission to higher-acuity care settings.
- **Limited-Service Options:** The scarcity of subacute and intermediary services, such as residential facilities with personalized care plans, IOPs, and supported living arrangements, force individuals to choose between insufficient OP services or potentially risky return to previous environments.
- **Fragmented System:** Silos between acute, subacute, and OP care impede transitions and comprehensive support, leaving individuals navigating a disjointed system.

Stakeholders indicated that addressing this critical need requires a strategic and data-driven approach such as:

- **Targeted Funding and Policy Initiatives:** Strategic investments are essential to develop and expand subacute and intermediary service programs across Montana. This includes financial investment for residential facilities, OP programs, and community-based support services.
- **Workforce Development and Retention:** Building a robust workforce of skilled professionals equipped to deliver these services is crucial. Competitive salaries, comprehensive training programs, and career development opportunities will attract and retain talent.
- **System Integration and Collaboration:** Breaking down silos and fostering collaboration between IP, subacute, and OP care is vital. Seamless transitions and information sharing will foster coordinated support throughout the recovery journey.
- **Data-Driven Decision Making:** Collecting and analyzing data on service utilization, outcomes, and cost-effectiveness can inform strategic planning and resource allocation, ensuring efficient and impactful interventions.

Closing the subacute and intermediary service gap is not simply about filling a void in the healthcare system; it is about creating a robust platform for recovery and empowerment for individuals with BH and I/DD needs in Montana. By establishing a continuum of care that caters to diverse needs and promotes gradual reintegration into the community, the State can make a tangible difference in the lives of individuals and families.

3. Workforce Limitations, Focusing on Direct-Care Staff

Interviewees acknowledged that Montana's BH and I/DD service system faces a critical workforce crisis, primarily impacting underpaid and overworked direct-care staff. Low wages, high turnover rates, and shortages in rural/frontier and urban areas disrupt care continuity. It was suggested that addressing the crisis involves strategic compensation adjustments, workforce development, flexible work arrangements, technology utilization, and improved retention strategies to strengthen the workforce and enhance overall well-being.

Across Montana, a chronic shortage of qualified and stable personnel is a critical challenge of the BH and I/DD service systems. The workforce crisis, which particularly impacts direct-care staff, presents a significant barrier to quality care, and hinders the system's ability to meet the needs of vulnerable populations. Factors offered by stakeholders included:

- **Low Wages and Benefits:** Compared to other professions with similar demands, direct-care staff in Montana are significantly underpaid, often receiving wages insufficient to cover basic living expenses. Additionally, limited benefits packages further disincentivize long-term commitment.
- **High Turnover Rates:** The demanding nature of the work, combined with low compensation and limited career advancement opportunities, leads to staff burnout and attrition. This instability disrupts continuity of care and negatively impacts service delivery.
- **Staff Shortages in All Regions:** The workforce shortage is not limited to rural/frontier areas. Even urban centers struggle to attract and retain qualified personnel, leading to increased caseloads and diminished individual attention for clients.

Per interviewees, addressing the crisis requires a multi-pronged approach:

- **Strategically Adjusted Compensation:** Implementing competitive salaries and comprehensive benefits packages, including healthcare, childcare assistance, and tuition reimbursement, is crucial to attract and retain qualified personnel.
- **Workforce Development Initiatives:** Investing in training programs, upskilling opportunities, and career advancement pathways can enhance professionalism, boost morale, and encourage long-term commitment within the workforce.
- **Flexible Work Arrangements:** Offering part-time, flexible scheduling, and remote work options can cater to diverse needs and attract individuals who might otherwise be excluded due to childcare or commuting challenges.
- **Leveraging** Technology**:** Utilizing telehealth tools can expand access to services in remote areas and reduce staff travel burdens, potentially easing workload and attracting geographically dispersed talent.
- **Improved Retention Strategies:** Providing ongoing support through mentorship programs, peer networks, and access to employee BH resources can help mitigate burnout and encourage staff to remain in the field.

Strengthening Montana's BH and I/DD system workforce requires strategic investments in the well-being of direct care staff. By prioritizing direct-care staff, interviewees believe the State can build a more resilient workforce capable of delivering quality care and promoting community integration.

4. Localized Crisis Management and Inpatient Reliance

Interviewees pointed to Montana's fragmented BH crisis services, amplified by its vast landscape, leading to systemic overreliance on high-cost, resource intensive IP care. Limited crisis hotlines and mobile crisis teams contribute to geographic disparities, pushing individuals to EDs, disrupting community support, and reinforcing stigma. Stakeholders suggested that creating a statewide crisis management system with robust communication networks, mobile crisis teams, and standardized protocols to improve accessibility, treatment outcomes, and overall crisis support in Montana would help with overreliance on IP care.

Montana's geography amplifies the by fragmented BH crisis services. With services siloed within individual localities, the State lacks a unified, coordinated system for managing BH emergencies. This patchwork approach has significant consequences, most notably a heavy reliance on expensive and often inappropriate IP care.

Local crisis hotlines, likely understaffed and operating with limited resources, may offer little beyond a distant voice and inadequate knowledge of statewide options. Mobile crisis teams, if available at all, might be restricted to urban centers, leaving those in smaller towns with no immediate option. These geographic disparities force people experiencing a BH crisis to seek help in the nearest available resource: the ED. In instances, law enforcement becomes a front-line responder to a BH crisis pulling them away from other duties and can result in the person experiencing the BH crisis being charged with a crime and incarcerated.

IP care, while crucial for acute BH needs is not necessarily the appropriate level of care for addressing most BH crises. In Montana, where rural/frontier residents face longer travel times and potential bed shortages, lengthy in-patient hospital stays contribute to a costly service mix and are not necessarily the appropriate level of care for the acuity of need. In addition, BH stigma, including in-patient BH care can prevent people from seeking help.

Stakeholders strongly stated the solution is in the development of community safety nets with IP use limited to those who need that level of care. Montana needs a statewide crisis management system that create seamless interconnectedness for people accessing services to provide continuity of care and be of true assistance to people on their journey of recovery. A statewide crisis management system would include:

- **Building a robust communication network:** Crisis hotline routed through a central hub equipped to assess BH needs, identify the appropriate level of response based on the screening, dispatch mobile crisis teams as determined through assessment (potentially expanding their reach through telehealth), and direct individuals to timely resources regardless of their location.
- **Investing in mobile crisis teams:** Mobile crisis teams can be comprised of BH professionals and peer support personnel to be deployed in person to meet with a person experiencing a BH crisis. The team would be trained in de-escalation tactics and work with the person to develop a safety plan and access to services.
- **Standardizing protocols and data sharing:** Consistent screening and assessment tools with data metrics and a shared data platform would foster real-time coordinated interventions improving the responsiveness and continuity of care.

Implementing a statewide BH crisis system requires a collaborative effort from state agencies, local providers, and community stakeholders including memorandums of understanding and

data sharing agreements. By investing in a community-based approach, Montana can reduce reliance on costly IP care, improve timely access to the appropriate level of care, improve treatment outcomes, and offer its residents help during a time of crisis.

5. Limited-Service Access in Frontier Regions

Stakeholders expressed that Montana's frontier regions grapple with significant BH service gaps due to limited access to care settings and qualified providers. Addressing root causes, such as socioeconomic inequities, requires targeted investments for behavioral healthcare professionals and regional hubs. Technology, including expanding broadband access and telehealth options, can play a crucial role in bridging the gaps in care in remote areas.

Interviewees were clear: residents in its frontier regions have greater challenges navigating the behavioral healthcare system, facing limited access to critical BH services. Unlike residents in urban centers, individuals in geographically isolated, sparsely populated areas encounter service gaps that necessitate the state making targeted efforts through unique care delivery models. The reasons behind these gaps include:

- **A Scarcity of Resources:** Access to qualified BH providers is lower in Montana's frontier regions. There is a critical shortage of psychiatrists, therapists, and other BH professionals. This scarcity forces individuals to travel long distances and overcome potential transportation and financial hurdles just to reach basic BH services or choose to forego seeking BH services all together.
- **Telehealth Is Not a Simple Solution:** The difference in geography in Montana's frontier communities pose a challenge for traditional BH service delivery models. While telehealth holds promise, its effectiveness hinges on reliable broadband infrastructure, a feature often absent in remote areas.
- **Addressing Root Causes:** The solution needs to go beyond medical and BH interventions. Social determinants of health impact physical and BH well-being. A successful strategy must acknowledge and address these SDoH factors alongside clinical care.
- **Building Sustainable Solutions:** Bridging the BH service gap in Montana's frontier communities require targeted investments. Developing solutions that mitigate challenges, including low population density, long travel times for in-person services, low patient census and limited BH workforce compromise feasibility of building and sustaining necessary behavioral healthcare services. These solutions could include:
    - Enhancing financial incentives and loan forgiveness programs tailored to attract and retain healthcare professionals in underserved regions.
    - Establishing regional community service hubs that co-locate multiple specialized services, coupled with mobile outreach teams, to serve geographically dispersed populations. It optimizes limited resources, keeping providers working in these communities engaged with meaningful work.
    - Collaborating with local community organizations, including Tribal partners to leverage existing community resources and build culturally appropriate support networks.
- Technology can be a powerful tool in enhancing and improving behavioral healthcare delivery in frontier regions of the State by:

- **Expanding broadband access and exploring alternative telehealth technologies** like satellite-based internet to make specialized behavioral healthcare or services easier to access in areas that lack the population density for feasible in-community BH services.
- **Investing in interactive online platforms and applications** to supplement and enhance the impact of support groups, disseminate information, and spread self-management resources.

6. Placement Challenges for Individuals with Multiple Diagnoses

Interviewees reported that Montana's healthcare system poses challenges for individuals with co-occurring physical and BH needs. Individuals with multiple BH diagnoses and/or additional I/DD and physical health diagnoses face limited placement options based on facility-imposed eligibility criteria and practices. This limited eligibility approach and scarcity of specialized facilities force difficult choices for individuals with co-occurring conditions. To address this, it is suggested that Montana should implement integrated care models, expand telehealth service access, and invest in rural/frontier outreach initiatives to create a more seamless and accessible path for those with multifaceted needs.

Navigating the healthcare delivery system in Montana is challenging for many, but for individuals with multiple diagnoses, particularly the co-occurrence of physical and BH needs, the journey becomes an arduous trek through a fragmented maze. This population often encounters significant hurdles in finding appropriate placement to meet their more complex needs, leading to inadequate support and hindered recovery.

- **Patients Get Lost in the System's Siloed Approach:** Traditional healthcare models in Montana struggle to wrap-around multiple conditions that need to be addressed for those with co-occurring conditions. Primary care physicians, while adept at managing physical ailments, may lack the training to identify and address BH conditions.
- **BH Staff have siloed training and focus**: BH specialists, focused on psychological well-being, might overlook, or underestimate the impact of co-occurring physical health issues. When residential or IP needs present for individuals with co-occurring disorders, placement options can be limited because care needs require organizational and staff readiness to accept clients with intersecting clinical needs. This siloed approach leaves individuals with complex needs falling through the cracks.
- **The Placement Paradox of Scarcity and Distance:** Even when appropriate care is identified, finding a BH provider in Montana can be burdensome. Specialized programs equipped to handle complex care needs are scarce, often concentrated in urban areas and geographically distant from rural/frontier communities. This forces individuals to make a difficult choice in seeking care to meet their unique needs.
- **Building a Path Forward for Integrated Care:** To create a service delivery system where individuals with complex needs are not lost or receive inadequate care. Stakeholders suggested the following changes:
  - **Implement Integrated Care Models:** Foster collaboration between physical and BH professionals within a single team, fostering a holistic approach to managing co-occurring conditions.
  - **Expand Telehealth Service Access:** Utilize telehealth technologies to bridge the geographic gap and give choice for people to connect with services.

- **Invest in Rural/Frontier Outreach:** Establish mobile outreach teams or satellite clinics in rural/frontier communities to deliver accessible care closer to home.

By acknowledging the distinct challenges faced by this population and prioritizing integrated care, telehealth expansion, rural/frontier outreach, and policy advocacy, Montana can advance the transformation of a quality behavioral healthcare system that can meet all of individual's needs.

7. Unmet Pediatric BH Needs

Stakeholders shared that Montana's lack of in-state treatment options for pediatrics with complex BH needs force families to choose between potentially ineffective local care and disruptive out-of-state placement. The impact of displacement goes beyond financial strain, negatively affecting treatment progress. To address this, it was surmised that Montana should expand in-state capacity, foster regional collaboration, leverage technology for expanded choice of access, and address systemic challenges.

Across Montana, a critical gap in the BH system leaves pediatrics with complex needs facing a stark reality: inadequate in-state treatment options and the undesirable choice of out-of-state placement.

- **A Scarcity of Specialized Services:** Montana's delivery system lacks the breadth and depth of specialized treatment programs needed for the pediatric population with conditions like severe emotional disturbances, autism spectrum disorder, and substance abuse. This deficit forces families into an inconvenient situation: accepting potentially ineffective local care, navigating a maze of OP interventions, or embarking on the disruptive journey of out-of-state placement.
- **Consequences of Displacement:** The impact of out-of-state placement reaches far beyond financial strain and the logistical challenges of maintaining long-distance connections. The disruption of familiar environments, support networks, and a sense of belonging can impede progress in treatment, exacerbate underlying conditions, introduce additional trauma, and impede treatment outcomes.
- **Charting a New Course:** To bridge this gap and prevent families from enduring this unnecessary hardship, stakeholders pointed to the following priorities:
    - **Expanding In-State Capacity:** Invest in developing and expanding specialized treatment programs within the State. This involves financial incentives, infrastructure development, and targeted workforce recruitment efforts to attract and retain qualified professionals.
    - **Regional Collaboration:** Foster partnerships between healthcare providers, educational institutions, community organizations, and government agencies to share resources, expertise, and best practices, enhancing in-state treatment options and reducing dependence on out-of-state placements.
    - **Leveraging Technology:** Explore the use of telehealth to give families a choice in connecting the pediatric population with specialized providers remotely, particularly in rural/frontier areas.,
    - **Addressing Systemic Challenges:** Examine and reform outdated funding models, administrative complexities, and restrictive insurance policies that hinder the development and accessibility of in-state services.

8. Inadequate Wraparound Services: Transportation and Housing

Stakeholders pointed to a lack of crucial wraparound services like transportation and housing, which impacts individuals and hampers the efficacy of clinical intervention. Limited rural/frontier transportation and a scarcity of affordable housing limit access to essential services. To address this, stakeholders suggest the State expand public transportation, develop affordable housing solutions, explore innovative funding models, and foster community collaboration.

While Montana has made strides in behavioral healthcare, a critical gap remains: the lack of adequate wraparound services like transportation and housing. This deficiency directly impacts individuals who require support beyond clinical intervention, leaving them struggling to reintegrate into their communities. Of note, since stakeholder conversations took place, Montana's HEART Tenancy Support Services were approved by CMS in February 2024.

- **The Missing Pieces of the Puzzle:** Effective BH treatment goes beyond the clinical settings. Post-discharge from an in-patient care setting, individuals need continued services and supports in their community to continue supporting them on their recovery journey. However, in Montana, a large barrier is insufficient transportation and scarce affordable housing options.
- **Transportation: A Roadblock to Independent Navigation of Care:** Public transportation options in Montana, particularly in rural/frontier areas, are limited and often inaccessible to individuals with disabilities. This lack of mobility restricts access to essential services, employment opportunities, and crucial support networks, hindering their ability to regain or maintain independence and manage their recovery.
- **Housing Insecurity: Fueling Instability:** The scarcity of affordable housing options, particularly those catering to specific needs like supportive living environments, leaves individuals vulnerable to instability and potential relapse. Homelessness further jeopardizes behavioral and physical well-being, making it difficult to maintain progress in treatment.
- **Charting a New Course:** To tackle this challenge and empower individuals to thrive within their communities, stakeholders suggested a multifaceted approach that includes:
    - **Expanding Public Transportation:** Increase public transportation options, particularly in rural/frontier areas, and prioritize accessible design features to cater to individuals with disabilities.
    - **Developing Affordable Housing Solutions:** Partner with public and private entities to develop and increase the availability of affordable housing options, including supportive living environments and accessible units.
    - **Exploring Innovative Funding Models:** Implement creative funding mechanisms, like Medicaid waivers or public-private partnerships, to support the development and sustainability of these services.
    - **Fostering Community Collaboration:** Build partnerships with local organizations, faith-based groups, and advocacy agencies to leverage resources, expertise, and create a comprehensive network of wraparound support.

By prioritizing the development of robust wraparound services, Montana can empower individuals on their recovery journey and as active members of their communities. This shift will

not only enhance individual well-being but also contribute to a stronger, more inclusive Montana by promoting greater engagement, self-sufficiency, and a sense of belonging.

9. Enhancing Peer-Support Services and Ancillary Professional Programs

Stakeholders indicated that Montana's behavioral healthcare system underutilizes peer-support services and ancillary professional programs, despite the potential they have in expanding capacity resulting in expanded access to services driving improved outcomes. Peer support specialists offer unique support for recovery, but challenges like inadequate funding, restrictive reimbursement, and the need for workforce development limit their current availability.

Some stakeholders believe an existing workforce resource goes underutilized: peer-support services and other ancillary professional programs as in augmenting care team options. Despite evidence-based support for their impact, stakeholders believe these programs face inadequate funding and restrictive reimbursement structures, limiting their reach and hindering their potential to provide support in the community.

- **Shared Experience:** Peer support, delivered by individuals with lived experience in BH or I/DD, goes beyond traditional models. This shared journey fosters unique understanding, validation, and guidance that traditional BH professionals cannot always replicate. Peers provide vital support, motivation, and lessons in self-management skills that can playing a crucial role in recovery.
- **Professionals: Bridging the Gap:** Certified counselors, case managers, and other ancillary professionals fill a critical gap in Montana's healthcare delivery system. Collaborating with other professionals, they can deliver crucial services, including individual attention, crisis intervention, and ongoing support, particularly in underserved rural/frontier areas.
- **Unlocking Potential: Challenges Remain:** Despite their effectiveness, stakeholders offered several factors that limit the reach and impact of these programs in Montana:
    - **Inadequate Funding:** Limited financial support restricts program expansion, particularly in rural/frontier areas, leaving many individuals without access to vital peer support and ancillary professional services.
    - **Restrictive Reimbursement:** Insurance policies and government funding mechanisms often fail to adequately reimburse these services, disincentivizing their integration into standard behavioral healthcare models.
    - **Workforce Development:** Building and sustaining a qualified workforce requires continued investment in training, certification, and career advancement opportunities for peers and other ancillary professionals.

10. Telehealth Expansion with Caution for Treating Severe Conditions

Telehealth offers potentials, including improved and convenient access. Stakeholders also cited limitations in telehealth's impact such as the digital divide and challenges in remote rapport-building and comprehensive risk assessment. Stakeholders suggest that safe implementation, addressing the digital divide, providing telehealth training, establishing high-risk protocols, and incorporating hybrid models of care are crucial for a comprehensive and secure BH network.

Telehealth offers significant potential to improve access to BH services in Montana, but its limitations must be considered for patient safety.

Benefits Cited:

- **Bridging the Distance:** Telehealth eliminates travel barriers, connecting individuals with BH professionals regardless of location. Studies show its effectiveness in treating conditions like depression, anxiety, and SUDs.[174]
- **Convenience and Flexibility**: Telehealth offers flexible scheduling and reduces travel hassles.

Limitations Cited:

- **Addressing the Digital Divide:** Lack of internet access in rural/frontier areas excludes some populations from benefiting from this care modality.
- **Rapport and Complex Interventions:** Building rapport and conducting nuanced assessments remotely can be challenging.
- **Risk Assessment and Crisis Intervention:** Remote communication may hinder accurate risk assessment and crisis intervention, potentially impacting patient safety.

Safe and Measured Implementation:

- **Telehealth Training for Providers:** Training in remote rapport building, risk assessment, and crisis management is essential.
- **High-Risk Protocols:** Clear protocols should identify and transition high-risk patients to in-person care.
- **Hybrid Models of Care:** Combining telehealth with in-person appointments can address limitations while offering flexibility.

Stakeholders suggested that telehealth should complement, not replace, traditional care, particularly for complex BH and I/DD cases. By addressing the digital divide, providing specialized training, and implementing clear protocols, telehealth can be a valuable tool for a comprehensive and safe BH network in Montana.

[174] Sugarman, Dawn E., Alisa B. Busch, R. Kathryn McHugh, Olivera J. Bogunovic, Catherine D. Trinh, Roger D. Weiss, and Shelly F. Greenfield. 2021. "Patients' Perceptions of Telehealth Services for Outpatient Treatment of Substance Use Disorders during the COVID-19 Pandemic." The American Journal on Addictions 30 (5): 445–52. https://doi.org/10.1111/ajad.13207.

Appendix D. National Best Practices & Comparable State Research Summary

Overview of Best Practice Research

The study team's approach involved an examination and analysis of practices in three core groups of states. The study team explored peer states, including Wyoming, South Dakota, North Dakota, and Oregon, for meaningful outcome comparison and parallels in program implementation. ACO state models, including Colorado, Minnesota, and Oregon, demonstrated different approaches to ACO frameworks for comprehensive understanding of ACO implementation. Alternative state models, including Alaska, Georgia, North Dakota, and South Dakota, offered innovated approaches to behavioral healthcare relevant to the questions examined for this design study.

Finally, the study team considered national best practices, which served as a foundation for identifying what could feasibly be adapted and implemented in Montana. The study team's recommendations were not only informed by what other states implemented but also tailored to the specific features, opportunities, and challenges present in Montana's BH ecosystem.

Best Practice Research: National Priorities

To put forth recommendations aligned with the goals of Montana's Alternative Settings project, significant research was completed regarding national trends and innovations in state behavioral healthcare delivery. Reviewing best practices, state investments, and academic propositions underscored **six central topics** fundamental to optimizing behavioral healthcare delivery.

1. At the forefront of these investments is a concerted effort to **integrate physical and behavioral healthcare** to reduce cost, improve overall client outcomes, and coordinate care overall[175],[176]
2. Across state policy, there is a growing understanding that Medicaid reimbursement drives the behavioral healthcare market, provider availability, and patient choice. **Optimizing Medicaid reimbursement rates** to expand care and increase provider reimbursement has been an area of focus across the United States.[177,178]
3. With the national introduction of 988 and expansion of mobile crisis unit programs, states are bolstering their ability to **respond in the community to BH crises** with the goal of preventing avoidable IP care.[179]
4. The utilization of **telehealth services** for OP physical and behavioral healthcare expanded during the US public health emergency and continues to be utilized in behavioral healthcare to expand provider catchment area, reach clients in rural/frontier

[175] Browning, "Medicaid Forward: Behavioral Health."

[176] Nardone, Snyder, and Paradise, "Integrating Physical and Behavioral Health Care: Promising Medicaid Models | KFF."

[177] Guth et al., "How Do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs | KFF."

[178] Cicerone, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*.

[179] Saunders, Guth, and Panchal, "Behavioral Health Crisis Response: Findings from a Survey of State Medicaid Programs | KFF."

regions of the country, and minimize workforce strain across the field.[180]

5. Concerning national pediatrics MH outcome reports have led to several states bolstering attention and investment in **pediatric behavioral healthcare** provision.[181]
6. **Peer support services**, and additional ancillary professional designations, have proved effective in optimizing the behavioral healthcare continuum at large. State programs for para-professional trainings have become increasingly popular and foundational to care coordination and service provision, particularly in rural states.[182]

Best Practice Research: State Examples

The exploration of best practices in BH research for the Alternative Settings study involved careful consideration of states that share similarities with Montana, termed as 'peer states.'

Similarities in geography and demography to Montana, the study team considered peer states to provide context for Montana's performance in BH outcomes. As demonstrated in Table 57, key indicators suggest Montana trends on the lower end of peer states, along with Wyoming. Montana has particularly low rankings related to substance use and pediatrics rankings.

Table 57. Adult and Pediatrics National Rankings[183]

Topics	Montana	Wyoming	South Dakota	North Dakota	Oregon
Adult Ranking* (overall)	29	**50**	40	**24**	48
Adults with SUD Rank (% Pop. affected)	**50 (19.2%)**	43 (17.6%)	47(18.6%)	**29 (16.4%)**	49 (19.1%)
Pediatric Ranking* (overall)	39	**17**	25	18	**51**
Pediatric with SUD Rank (% Pop. affected)	**50 (8.6%)**	35 (6.9%)	43 (7.4%)	**27 (6.5%)**	49 (8.0%)

Table Note: Rankings informed by measures of prevalence of mental illness/SUD and access to care.

Innovative programs and policies related to BH service provision relevant to the goals of the Alternative Settings study

The study team further examined seven states, found in Table 58, for their approaches to statewide oversight, care coordination, and quality improvement in behavioral healthcare.

[180] "Telehealth Use in Rural Healthcare Overview - Rural Health Information Hub."

[181] Bell et al., "The Impact of COVID-19 on Youth Mental Health: A Mixed Methods Survey."

[182] "Peer Support: Research and Reports."

[183] "America's Health Rankings | AHR." 2016. America's Health Rankings. 2016. https://www.americashealthrankings.org.

Table 58. Innovative Programs and Policies by State

State	Programs and Policies
 ***Colorado***[184,185,186]	**Colorado** implemented a transformative approach by establishing seven contracted regional accountable entities (RAEs) to support a local network of primary care medical providers. These entities were entrusted with the coordination of members' care across systems and held responsible for both the cost and quality of care delivered. 97% of Medicaid enrollees in Colorado became part of this innovative system. Since the inception of the RAEs in 2018, Colorado has reported an increase in Medicaid enrollees receiving BH services.
 **Minnesota**[187,188,189]	**Minnesota** incorporated behavioral healthcare oversight into the responsibilities of 26 IHPs across the State. These IHPs were mandated to develop and implement specific health initiatives, address social risk factors, and adhere to rigorous quality and performance measures. The impact of this initiative is substantial, as IHPs in Minnesota now serve a considerable population of 430,000 individuals.
 **Oregon**[190,191]	**Oregon** initiated its accountable care program, introducing 15 coordinated care organizations to enhance healthcare delivery and reduce overall costs. By mid-2015, the State achieved a commendable 23% reduction in ED utilization through its CCO initiative.
 ***Alaska***[192]	**Alaska** took significant steps in 2016 when legislators passed SB 74 to enhance the effectiveness, efficiency, and integration of Alaska's BH system. This legislation paved the way for two key initiatives: the Alaska 1115 Demonstration Waiver Project and the ASO implementation. ASOs are tasked with increasing access to BH services, improving outcomes, and reducing the costs of services.
 **Georgia**[193]	**Georgia** stands out with its exemplary crisis system, boasting a 24/7/365 crisis line operating on a clinical triage model, a bed registry integrated with the crisis system, and mobile crisis teams collaborating with law enforcement. Georgia HB 514 established the Georgia Behavioral Health Reform and Innovation Commission. In 2022, the commission focused on addressing the BH workforce shortage, promoting data collection, building a robust crisis system, expanding successful community-based practices, and streamlining policies and statutes.

[184] Kaye, "Three States' Strategies to Improve Behavioral Health Services Delivery through Medicaid Accountable Care Programs."

[185] Gordon, "Integrating Behavioral Health into Accountable Care Organizations: Challenges, Successes, and Failures at the Federal and State Levels."

[186] "Accountable Care Collaborative Phase II: Framework for Behavioral Health Reimbursement."

[187] Kaye, "Three States' Strategies to Improve Behavioral Health Services Delivery through Medicaid Accountable Care Programs."

[188] Gordon, "Integrating Behavioral Health into Accountable Care Organizations: Challenges, Successes, and Failures at the Federal and State Levels."

[189] "Integrated Health Partnerships (HIP)."

[190] Gordon, "Integrating Behavioral Health into Accountable Care Organizations: Challenges, Successes, and Failures at the Federal and State Levels."

[191] Holder, "Medicaid ACOs Oregon."

[192] Moreau and Brown, "Medicaid Section 1115 Behavioral Health Waiver Demonstration Project."

[193] "Georgia Behavioral Health Reform and Innovation Commission: 2022 Annual Report."

State	Programs and Policies
 **North Dakota**[194]	**North Dakota's** BH system identified a statewide need for strengthening rehabilitative and community-based services, reducing emphasis on acute and crisis services. In response, the North Dakota Department of Health created Community Connect, aiming to expand quality, community based BH services. This initiative includes a specific focus on training, funding for care coordinators, peer support services, and rehabilitation services.
 **South Dakota**[195]	**South Dakota's** approach involves contracting with 11 regional community mental health centers and 40 provider organizations for SUD services. The State utilizes a combination of mobile crisis teams and virtual crisis response support (using iPads in rural and frontier areas) to provide crisis response services in both populated and frontier areas of the state. Systems of Care, a coordination service, focuses on the pediatric population and families with complex care needs. Through various state bills and funding allocations between 2020-2023, South Dakota has invested significantly in appropriate regional facilities, intended to provide 24/7 overnight residential services to stabilize acute psychiatric needs closer to home.

[194] "Community Connect."

[195] "Behavioral Health General Information," South Dakota Department of Social Services, 2022, https://dss.sd.gov/behavioralhealth/.

Appendix E. Second-Tier Recommendations

In Appendix D, the study team offers a series of recommendations that, while valuable and well-considered, did not score as an initial priority for impacting the BH ecosystem (please refer to the main report). These additional recommendations, though not featured prominently in the primary report, are integral findings per the design study. Recognizing the importance of thorough exploration and diverse perspectives, these additional recommendations are also evidence-based, stakeholder-informed and represent promising opportunities to the State to optimize a next-generation BH system.

1. Continuum of Care

Promote increase in use of telehealth, telemedicine, and telepsychiatry for appropriate cases.

Factors Supporting the Recommendation

Expansive Geography and Limited Workforce:

- **Vast distances and limited providers:** Montana's vast geography and dispersed population create significant challenges in accessing BH specialists, especially in rural/frontier areas Telehealth eliminates geographical constraints, allowing individuals to connect with providers virtually, regardless of their location.
- **Provider shortages:** Montana faces a shortage of BH professionals, particularly in rural/frontier areas Telehealth can help bridge this gap by enabling providers to serve individuals remotely.

Enhancing Convenience and Flexibility:

- **Reduced travel time and cost:** Telehealth eliminates the need for travel to appointments and reduces transportation-related barriers.
- **Increased appointment availability:** Telehealth appointments can often be scheduled outside of traditional office hours, making it easier for individuals to access care.
- **Increased care for the pediatric pediatrics:** Telehealth options can be offered during school hours to the pediatric population eliminating the need for adult transportation and reliable internet access in the home.

Improving Individual Engagement and Outcomes:

- **Reduced stigma:** Telehealth can help reduce the stigma associated with seeking BH treatment by offering a more private and convenient option.
- **Increased treatment adherence:** The ease and flexibility of telehealth appointments can lead to improved treatment adherence and better overall outcomes.
- **Enhanced individual-provider relationships:** Telehealth platforms can facilitate communication and collaboration between individuals, providers, and caregivers, potentially leading to more effective treatment plans.

Raise awareness of Medicaid reimbursement for psychiatrists providing consult services to other providers.

Factors Supporting the Recommendation

Improved Individual Care:

- **Early intervention and diagnosis:** Timely consultation with a psychiatrist can lead to earlier identification and diagnosis of BH conditions, enabling early intervention and potentially preventing more severe symptoms and/or complications.
- **Enhanced treatment planning and coordination:** Collaboration between PCPs and psychiatrists can lead to more comprehensive and effective treatment plans that address both the physical and BH needs of individuals (as well as co-occurring conditions).
- **Reduced healthcare utilization:** Effective consultation can help prevent unnecessary ED visits, hospitalizations, and other costly healthcare interventions associated with untreated or poorly managed BH conditions.

Increased Access to Care:

- **Reduced burden on PCPs:** By providing consultation and support, psychiatrists can alleviate the burden on PCPs who may not have the training or expertise to manage complex BH cases.
- **Improved access to specialty care:** In rural/frontier areas where psychiatrists are scarce, consultation services can bridge the gap and increasing individuals' access to necessary specialty care.
- **Reduced disparities in care:** Raising awareness about reimbursement can promote equitable access to psychiatric consultation services for all Medicaid enrollees, regardless of their location or socioeconomic status.

Continue and expand commitment to BH-focused public education campaigns.

Factors Supporting the Recommendation

- **Promote help-seeking behaviors:** Public education campaigns can provide information about available BH resources and encourage individuals to seek help early on when concerns first arise This can lead to timely intervention, better treatment outcomes, and improved overall well-being.
- **Empower individuals and communities:** Education empowers individuals to take charge of their BH and make informed decisions about seeking help It also empowers communities to create supportive environments where BH is openly discussed and addressed.
- **Educate family members and caregivers:** Expansion of knowledge of where, when, and how BH services can be accessed will allow family, friends, and caregivers to seek treatment in the appropriate setting and at the appropriate time.

Create dedicated resource to align grant-funded and Medicaid funded investments to address SDoH needs.

Factors Supporting the Recommendation

Addressing Fragmentation and Inefficiencies:

- Currently, grant-funded and Medicaid-funded initiatives addressing SDoH needs often operate in silos, leading to fragmentation and duplication of efforts. A dedicated resource can bridge this gap, fostering collaboration in the delivery of care and ensuring coordinated investment across different funding streams.
- Lack of coordination can create confusion and inefficiencies, making it difficult for individuals and communities to access and navigate available resources effectively. A centralized resource can facilitate service delivery and maximize the impact of available funding.

Promoting Sustainability and Scalability:

- Aligning funding streams can create a more predictable and sustainable source of support for SDoH initiatives, helping them develop long-term plans and secure stable funding.
- A centralized resource can play a key role in promoting the scalability and replication of successful SDoH programs across different communities and regions in Montana.

Create statewide formal notification and care coordination procedures between 988 call centers and BH service providers.

Factors Supporting the Recommendation

Enhance Continuity of Care:

- **Seamless transitions:** Formal procedures promote timely and accurate information sharing between call centers and providers, facilitating smooth transitions for individuals seeking care after contacting 988. This reduces the risk of care fragmentation and delays in receiving appropriate treatment.
- **Informed care planning:** Call triage operators can direct which type of providers respond to the individual in crisis based on the individual's condition and inform treatment plans more effectively, addressing specific needs and concerns identified during the initial 988 call.
- **Database of real-time availability:** Enhancing the BH system, a real-time crisis stabilization bed availability database can boost access to care, optimize resource allocation, and improve outcomes for individuals in crisis, fostering a more efficient and effective BH system.

Improve Resource Utilization and Efficiency:

- **Targeted referrals:** Clear procedures will be outlined ensuring individuals are connected to the most appropriate BH services based on their needs and geographic location, avoiding unnecessary referrals, and optimizing resource allocation.
- **Reduced redundancy:** Standardized communication protocols minimize the need for duplicate data entry and redundant information gathering, streamlining workflows for both call centers and providers.

Invest in transportation for individuals with BH conditions (specifically in rural/frontier and hard-to-access communities).

Factors Supporting the Recommendation

- **Need to address transportation deserts and improve rural/frontier access to healthcare**: Limited public transportation and long distances present significant barriers to accessing essential BH or any medical services, particularly for residents in rural/frontier areas.
- **Improve access to critical resources**: Investments in transportation can improve access to facilities with essential services crucial for maintaining good health and managing BH conditions.[196]
- **Reduce social isolation and promote community engagement**: Reliable transportation options can allow individuals to participate in social activities, support groups, and community events, contributing to improved BH and well-being and preventative services.

2. Access

Invest in statewide supportive housing.

Factors Supporting the Recommendation

Addressing Housing Instability and Homelessness:

- **Safe and stable housing:** Supportive housing provides individuals with a safe and stable place to live, which is fundamental for managing BH conditions Lack of stable housing is a significant factor in exacerbating BH issues.
- **Addressed SDoH:** Supportive housing can provide wrap-around services including food, clothing, furniture, employment training, job placement, and more permanent housing.

Enhancing Access to BH Services and Support:

- **Integrated care model:** Supportive housing programs can integrate on-site or readily accessible BH clinical services, including medication management, therapy, and case management. This model provides holistic support and removes barriers to accessing care, leading to better treatment adherence and improved health outcomes.
- **Reduced healthcare costs:** By addressing the root causes of BH challenges and preventing crisis situations, supportive housing can lower healthcare costs associated with ED visits, hospitalizations, and other costly interventions.

Promoting Social Integration and Independence:

- **Empowerment and self-sufficiency:** Supportive housing provides individuals with the tools and resources they need to develop skills, manage their conditions, and live independently. This fosters empowerment and self-sufficiency, promoting social integration and improving their quality of life.

[196] "Social Determinants of Health Series: Transportation and the Role of Hospitals | AHA," American Hospital Association, November 15, 2017, https://www.aha.org/ahahret-guides/2017-11-15-social-determinants-health-series-transportation-and-role-hospitals.

Redistribute and/or increase capacity of adult residential MH, SUD sub-acute beds.

Factors Supporting the Recommendation

Improving Access to Care:

- **Expanded IP capacity**: Adding residential beds for MH or SUD will expand IP bed capacity by transitioning patients occupying IP beds to step-down facilities when clinically appropriate. Additionally, individuals in crisis, who need a sub-acute level of care, can be admitted to residential facilities to promote timely interventions and treatment, preventing the over-utilization of IP beds.
- **Reduced geographic disparities**: Redistributing and adding residential beds, particularly in rural/frontier areas with bed shortages, can address access to care issues and overuse of emergency and acute IP services.

Enhancing Treatment Effectiveness:

- **Tailored interventions:** Sub-acute beds provide a structured environment for intensive treatment, counseling, individual and group therapy, and stabilization, offering more comprehensive interventions than OP settings for individuals requiring additional support.
- **Reduced risk of relapse:** Access to sub-acute beds allows individuals to access ongoing support and monitoring, reducing the risk of relapse and promoting sustained recovery.

Optimizing System Efficiency:

- **Streamlined service delivery:** By aligning bed capacity in different setting types with actual community needs, the system can operate more efficiently and economically by minimizing unnecessary transfers and ensuring individuals receive the most appropriate level of care.
- **Reduced burden on emergency services:** Increased availability of sub-acute beds can divert individuals from EDs and hospitals for non-emergency psychiatric or SUD-related needs, alleviating pressure on these often-overcrowded facilities.

Provide acute psychiatric beds in northern / eastern part of Montana.

Factors Supporting the Recommendation

Improve Access to Critical Care:

- **Reduced travel burden:** Individuals experiencing crises currently face long distances to access acute psychiatric care, often in urban areas far from their homes This creates delays in receiving necessary care and distances them from their support network. Providing local beds eliminates this burden, ensuring timely access to care during critical moments.
- **Reduced healthcare disparities:** The current geographic distribution of acute beds, concentrated in Region 4, exacerbates existing disparities in access to behavioral healthcare, particularly for rural/frontier residents. Placing beds in underserved areas fosters equity so that residents can receive necessary treatment regardless of their location.

Enhance Crisis Intervention and Stabilization:

- **Prompt intervention**: More acute psych beds in northern/eastern MT allow for timely support and keep individuals closer to their family and support network. IP care should only be recommended when necessary, such as severe cases, limited local resources, or integrated crisis stabilization units within the hospital.
- **Stabilization and treatment initiation**: Acute beds provide a safe and secure environment for stabilization, medication management, and initial treatment, offering a crucial bridge between crisis intervention and longer-term treatment plans.

Strengthen Community-Based Support Systems:

- **Reduced strain on local resources:** The availability of local acute beds alleviates pressure on EDs, law enforcement, and other local resources often called upon to manage BH crises. This allows these systems to focus on their core functions and improves overall community response to BH needs.
- **Continuity of care:** Having local beds facilitates smoother transitions back into the community after stabilization, allowing individuals to access ongoing support services closer to their homes and social networks.

Increase inpatient acute care capacity in Montana, to serve the pediatric population younger than 12 years.

Factors Supporting the Recommendation

Ensuring Timely and Appropriate Care:

- **Immediate intervention:** Pediatrics experiencing acute BH crises require specialized care and intervention as soon as possible. Currently, they often face long wait times and out-of-state transfers for appropriate individual care, delaying critical interventions and potentially worsening their condition(s).
- **Specialized treatment:** Pediatrics have unique developmental needs and require specialized approaches to BH treatment. Existing adult-focused facilities may not have the expertise or resources tailored to effectively address the specific needs of this age group.

Allocating costs appropriately:

- **Reduced expenses:** Currently, Montana is spending over 80% of its Medicaid pediatric expenses on 20% of the pediatric population receiving care. This is mostly due to the pediatric population being sent out –of-state for treatment. Costs could be reduced by providing services within the State.

Reducing Trauma and Burden on Families:

- **Minimizing disruption:** Long-distance transfers and out-of-state placements create significant stress for the pediatric population and additional trauma and expense for their families. Local individual care minimizes disruption and allows families to remain involved in the treatment process, providing crucial support and promoting better outcomes.

Improving Long-Term Outcomes:

- **Early intervention:** Timely access to effective treatment during critical moments can significantly improve long-term BH outcomes for. the pediatric population. Delays in accessing appropriate care can exacerbate symptoms and increase the risk of future complications.

- **Continuity of care:** Having local individual care facilitates smoother transitions to community-based treatment settings, ensuring continuity of care and supporting sustained recovery.

Develop decentralized inpatient spokes across the State to reduce pressure on MSH (hub) and increase capacity.

Factors Supporting the Recommendation

Improve Access to Care:

- **Reduced travel burden**: Spokes located in different regions can significantly reduce travel distances for individuals requiring individual care, improving timely access to essential services, especially for those residing in rural/frontier areas. This can minimize barriers for individuals and their families.
- **Reduced wait times**: By distributing individual volume across multiple facilities, decentralized spokes can alleviate pressure on MSH, potentially reducing wait times for admission and ensuring individuals receive prompt intervention during critical moments.
- **Increased Patient Satisfaction**: Offering care closer to home will allow for the added convenience of patients and enables support from nearby family, caregivers, and friends.

Enhance Capacity and Efficiency:

- **Increased bed availability:** Establishing additional facilities would create more individual beds overall, expanding the State's capacity to serve individuals with acute BH needs, which can help address the current shortage of beds in specific regions and improve overall system efficiency.
- **Specialized care closer to home:** Decentralized spokes can be tailored to address specific regional needs and populations, potentially offering more specialized care options closer to individuals' homes and communities.

Strengthen Community-Based Support:

- **Continuity of care:** Having spokes integrated into local communities can facilitate smoother transitions between sub-acute and community-based support services, fostering continuity of care and promoting long-term recovery.
- **Community engagement:** Decentralized facilities can foster stronger partnerships and shared staffing with local healthcare providers, social service agencies, and community organizations, creating a more collaborative and responsive behavioral healthcare system.

3. Workforce

Enhance reimbursement in rural and frontier markets to incentivize existing workforce to serve the Medicaid population.

Factors Supporting the Recommendation

Incentivizing Existing Workforce:

- **Addressing financial barriers:** Lower volumes in rural and frontier markets often create financial disincentives for BH professionals to serve Medicaid individuals, leading to workforce shortages and limited care access. Increasing reimbursement rates in rural

and frontier markets makes working with the Medicaid population financially more attractive, encouraging existing providers to expand their caseload and accept new Medicaid individuals.

- **Retaining experienced providers:** Higher reimbursement rates can help retain experienced BH professionals already working in rural/frontier areas who might otherwise seek opportunities with higher earning and volume potential elsewhere. This promotes continuity of care and fosters stronger provider-client relationships.

Attracting New Professionals:

- **Competitive compensation:** Enhanced reimbursement rates make rural and frontier BH positions more competitive compared to urban areas or private practice settings, attracting new professionals willing to work in underserved communities. This expands the available workforce and increases access to care for Medicaid recipients.
- **Financial incentive for training:** Higher reimbursement can incentivize healthcare professionals to pursue additional training or specialization in BH treatment, increasing the number of qualified providers able to serve the Medicaid population effectively.

Add BH fellowships for integrated primary care residencies.

Factors Supporting the Recommendation

Strengthen the Integrated Care Workforce:

- **Increased number of qualified providers:** BH fellowships equip primary care residents with the skills and knowledge to effectively identify, manage, and treat common BH conditions within their primary care practice. This expands the pool of qualified providers delivering integrated care.
- **Enhanced competency and confidence:** The fellowship experience provides residents with in-depth training and supervised clinical practice, fostering greater confidence and competency in managing BH concerns within the primary care setting.

Improve Access to Integrated Care:

- **Reduced service gaps:** By increasing the number of PCPs having the skills to identify and address essential BH services existing gaps in care will be fulfilled, especially in rural/frontier and other underserved areas throughout the State.
- **Early intervention and treatment:** Integrating BH into primary care allows for earlier identification and intervention for BH concerns, preventing disease escalation and the need for more services.
- **Improved care coordination:** Collaboration between PCPs and BH specialists within the same practice fosters smoother care coordination and reduces fragmentation in service delivery.

Expand trainings for traditional and ancillary BH workforce to optimize their scope of practice to support community behavioral healthcare and build on existing education initiatives (e.g., universities, residencies, and fellowships).

Factors Supporting the Recommendation

Addressing Workforce Shortages:

- **Increased capacity:** Equipping more professionals with the skills and knowledge to effectively manage BH needs allows them to take on a wider range of responsibilities,

alleviating some of the burden on traditional providers and increasing overall system capacity.

- **Diversifying the workforce:** Ancillary providers, such as peer support specialists and community health workers, can play a crucial role in filling gaps in service delivery, particularly in rural/frontier areas. Expanding training opportunities attracts and develops talent in these critical roles.

Optimizing Scope of Practice:

- **Enhanced skills and knowledge:** Targeted training can equip professionals with the necessary skills and knowledge to manage specific BH conditions and interventions, allowing them to provide more comprehensive care within their scope of practice.

Appendix F. Tribal Specific Recommendations

A foundational component of the Alternative Settings project was stakeholder engagement alongside a design study of the current BH system in Montana and its impacts on Tribal communities in the State to understand what gaps exist specific to the Tribal population. As explored in Appendix B, population health outcomes suggest Tribal communities in Montana carry a disproportionate burden of BH diagnoses and adverse outcomes. As such, engagement with Tribal communities was paramount to this study.

To engage Tribal communities and obtain their input, the study team held several listening sessions with various Tribal groups and leaders. Recognizing that multiple, diverse Tribal Nations are a part of Montana, multiple opportunities for feedback from leaders and representatives from Tribal communities were necessary. Tribal community representatives were invited to committee proceedings throughout the Alternative Settings project. Members of the study team traveled to Montana in December to present and attend the Bozeman On-Site Tribal Convening. The study team also conducted one-on-one meetings, as well as collective listening sessions, with Tribal members to get feedback regarding BH service programming and priority needs.

Insights and feedback from all the listed engagements led to the alignment of recommendations with Tribal community needs in the following section. The recommendations listed align with the main body of the state reported recommendations. However, specific priorities and actions under each primary recommendation highlight how these recommendations could be applied to Tribal community needs and priorities. All recommendations are based on Tribal membership input as well as the study team's research and analysis, but funding and implementation is fully at the discretion of Montana DPHHS and the HB 872 Commission.

Primary Recommendations to Support Tribal Communities

Click on the following link, **Recommendation 1.3. Incorporate culturally relevant care protocols (Tribal and others) and hire culturally relevant staff**., or see details on page 25.

Secondary Recommendations to Support Tribal Communities

1. Continuum of Care

Develop a statewide comprehensive care management role or entity to facilitate care coordination between participants in Montana's system.

Comprehensive Care Management: Culturally relevant care coordination services can be provided to Native American individuals receiving care on and off the reservation to provide continuity across settings. This can be accomplished through a designated American Indian Care Manager to coordinate care for Native American participants through the selected governmental office by the BHSFG Commission.

Enhance existing infrastructure and resources - CCBHC, mobile crisis, PACT/ACT, school-based programs with sustained funding.

CCBHC: Additional coordinated services will be offered in rural and frontier areas, blending physical and behavioral aspects of care. CCBHC providers must maintain training in Tribal culture if their clinic services Native American clients per federal guidelines. CCBHCs are designed to offer multiple services in proximity and/or at one site.

Mobile Crisis: Identify additional mobile crisis resources and staff with culturally appropriate training in Tribal customs and lived experience to bring BH specialists to the reservations and Tribal communities regularly.

School-based Programs: Offer telehealth services in all regions to the pediatric population during, or preferably after school hours, to eliminate transportation issues to appointments and promote better access to care. Develop awareness program to notify school administrators, nurses, social workers, and parents or caregivers that this service is available to students.

Expand the use of integrated behavioral care models to support collaboration through partnerships with primary care and BH providers.

Integrated Behavioral Care Models: Provide culturally appropriate training for those practicing in rural and frontier Tribal lands to incentivize provider coverage. Include social workers, peer support specialists, psychologists, and psychiatrists in the care team. Plan to work and integrate services and providers with Tribal entities. Increase awareness around training for diverse types of BH providers reimbursed in each Tribal agreement.

Spread awareness of Medicaid reimbursement for mobile crisis services (recent State plan amendment) to encourage its expanded utilization.

Spread Awareness of Mobile Crisis Reimbursement: Promote awareness of Medicaid reimbursement for mobile crisis services through the recent Medicaid State Plan Amendment, Crisis Now Model, approved in mid-August 2023, by creating a sustainable system that prioritizes accessibility, empowers providers, and breaks down barriers to promote comprehensive and timely BH healthcare for all. Tribal members can have the opportunity to form mobile crisis teams on reservations and in urban areas to enhance culturally relevant assistance to Tribal members.

Invest in transportation for individuals with BH conditions (specifically in rural/frontier and hard-to-access communities).

Invest in Transportation for the Rural and Frontier Populations: Address transportation deserts and improve rural/frontier access to healthcare eliminating barriers to accessing essential BH or any medical services. Investments in transportation can improve access to facilities with essential services crucial for maintaining good health and managing BH conditions. Reliable transportation options can allow individuals to participate in social activities, support groups, and community events, contributing to improved BH and well-being and preventative services.

Promote increase in use of telehealth, telemedicine, and telepsychiatry for appropriate cases.

Increase Telehealth/Telepsychiatry: Utilize telehealth/telepsychiatry services during, or preferably after school hours to eliminate transportation requirements to appointments, which lessens family and caregiver burdens, alleviates connectivity issues, and promotes compliance with scheduled treatment. This is particularly challenging for the Native American pediatric population in rural and frontier areas, who lack access to reliable transportation and Internet. For adults, evaluate optimal Tribal sites of care including meeting houses, spiritual centers, or mobile vans as convenient access points for telehealth services.

Develop a telehealth program so that Tribal members can access knowledge keepers. Each Tribe could have a representative or their own cultural knowers advise on the BH development, implementation, and maintenance.

Raise awareness of Medicaid reimbursement for psychiatrists providing consult services to other providers.

Raise Awareness of Medicaid Psychiatrist Consult Reimbursement: Provide psychiatrist consultation and support services to alleviate the burden on PCPs who may not have the training or expertise to manage complex BH cases. In rural/frontier areas, where many Tribes are located, psychiatrists are scarce. Consultation services can bridge the gap and increase individuals' access to necessary specialty care.

Continue and expand commitment to BH-focused public education campaigns.

Promote BH Public Education Campaigns: Develop cultural and language appropriate BH campaigns to educate Tribal communities on services available statewide as well as help non-indigenous stakeholders become informed of cultural differences.

Create dedicated resource to align grant-funded and Medicaid funded investments to address SDoH needs.

Create Resource to Align Funding for SDoH: Assist Tribal Nations to apply for grant funding – Medicaid, IHS, SAMHSA, CMS, etc. to address SDoH.

Create statewide formal notification and care coordination procedures between 988 call centers and BH service providers.

Create Notification and Coordination between 988 and BH Service Providers: Identify Native American peer support specialists and family supports, Crisis Coordinators, and BH Leaders to incorporate in-state database as a trusted resource to provide culturally appropriate responses to crisis situations impacting Native American individuals and their families.

2. Access

Expand community-based crisis receiving and stabilization centers.

Expand Crisis Receiving and Stabilization: Divert patients from EDs, jails, and state-run healthcare facilities through recently earmarked $7.5 million near-term initiative funds for supports for mobile crisis response and crisis receiving and stabilization services. The initiative aims to further expand community-based crisis receiving and stabilization centers to bolster resources for providers, further diminishing the need for emergency rooms, jails, and state-run facilities.

Expand access to Comprehensive Behavioral Healthcare Campuses, especially in the east to improve transitions between inpatient, sub-acute, and outpatient (OP) care.

Enhance Access to Comprehensive Behavioral Healthcare Campuses: Increase access to Comprehensive Behavioral Healthcare Campuses to address significant gaps in care that exist across the State, particularly Regions 1 and 2. Since many of these areas are on or near Tribal lands and Tribal residents, the addition of settings would have a significant impact on bringing care closer to home. The State should align facility development with the Red Star 8 Nations proposed Healing Center in Montana. (Five Montana Tribes and the urban Indian Health

Centers have incorporated a new nonprofit, Red Star 8 Nations, which is planned to house a new regional Healing Center to provide residential and IP treatment services, resulting in a stronger continuum of care for Tribal communities. This Healing Center can help Montana meet the needs of high service utilizers, including the Medicaid population, needing residential and IP treatment.

Increase capacity of in-state residential treatment and group homes for the pediatric population to reduce out-of-state care.

Increase Youth Residential Treatment and Group Homes: Evaluate the most significant access gaps to youth residential and group home care for the Native American pediatric population, accounting for capacity additions that will occur through the addition of the Healing Center, proposed by Red Star 8 Nations, to determine areas of greatest need. Best practice relies on keeping the pediatric population close to home, in a supportive environment, with provider knowledge of lived experiences. Develop reimbursement structure that allows for smaller four-bed facilities treating medically complex patients, or in remote areas where demand is lower, to support long-term financial viability.

Redistribute and/or increase capacity of adult residential MH and SUD sub-acute beds.

Redistribute or Increase Capacity of MH and SUD Beds: Add or realign residential beds for MH or SUD to expand IP bed capacity by transitioning patients occupying IP beds to step-down facilities when clinically appropriate. Redistributing and adding residential beds, particularly in Tribal, rural, and frontier areas with bed shortages, can address access to care issues and overuse of emergency and acute IP services. This also results in promoting timely interventions and treatment and prevents the over-utilization of IP beds.

Invest in supportive housing statewide.

Enhancing Native American Supportive Housing: Provide investment for supportive and step-down recovery housing for Native American people that addresses Tribal customs and traditions in Montana. Additionally, Tribal communities have reported that there are significant housing gaps that contribute to poor BH outcomes among Tribal communities. Improving housing infrastructure in communities is essential to solidifying baseline foundational SDoH needs that directly impact the BH of all populations.

Provide inpatient acute care capacity in Montana to serve the pediatric population younger than 12 years.

Increasing acute care capacity for the pediatric population <12 years: Provide options for the Native American pediatric population to receive culturally appropriate care in Montana, rather than in Arizona, Washington, or the Dakotas, would allow family and caregivers an opportunity to be involved in the healing process and better transition the pediatric population to step-down and home-based settings.

Provide acute psychiatric beds in northern / eastern part of Montana.

Add Acute Psychiatric Beds in Northern and Eastern Montana: Place beds in underserved areas to foster equity so that residents can receive necessary treatment regardless of their location. This will reduce BH disparities related to acute care, minimize travel burdens on individuals and caregivers, allow for more frequent family involvement, and reduce the strain on local law enforcement.

Develop decentralized inpatient spokes across the State to reduce pressure on MSH (hub) and increase capacity.

Build Hub and Spoke Model: Build decentralized spokes (IP facilities) that can be tailored to address specific regional needs and populations, potentially offering more specialized care options closer to individuals' homes and communities, which would be more efficient for residents living in rural and frontier areas.

3. Workforce

Create dedicated provider recruitment and retention unit within state government to support expansion and maintenance of homegrown BH workforce.

Expand Native American BH workforce to increase culturally appropriate care. Allocate recruitment resources to Tribal communities to outline BH career opportunities in Montana. For high school, community college, and university students focusing on grants, loan forgiveness, and scholarship opportunities for working in rural and frontier areas, lifestyle, and community giveback.

Evaluate the sustainability of expanding the scope and/or use of ancillary providers (e.g., peer support specialists, community health workers, family caregivers) to deliver BH-related services and integrate these providers into BH care teams.

Expand scope of practice for ancillary providers to integrate into BH care teams: Enhance and expand training or use existing Native American peer support specialists, community health workers, and family caregivers to provide BH support services as an integral part of the BH team. Create clinical policy and procedures that encourage providers to practice to their highest licensed capabilities to optimize the workforce and support underserved communities, including Tribal communities.

Add BH fellowships for integrated primary care residencies.

Determine if any Tribal primary care physicians are interested in pursuing BH Fellowships: Depending on Tribal interest level, add BH Fellowships for primary care physicians. Engage primary care physicians who will work on reservations and/or regularly care for Native American individuals to expand service delivery potential of these providers.

Expand training for traditional and ancillary BH workforce to optimize their scope of practice to support community behavioral healthcare.

Offer Tribal-specific trainings for BH workforce: Use existing tribal forums or a new initiative led by the Office of American Indian Health to provide a framework for each of the Tribal Nations to collaborate on key teachings and shared topics for educating providers and addressing BH care. At the same time, Tribes can customize the teaching materials to address each individual Tribe’s customs to include in continuing education and BH certification and degree-based program materials to be taught at universities, colleges, and in required licensure renewal classes.

Appendix G. Pediatric Specific Recommendations

The Alternative Settings design study focused on ways to improve BH services and infrastructure in Montana for all residents, pediatrics, and adults. Given the unique needs of the pediatric population, treatment program specificities, and essential developmental considerations, the study required unique attention to the pediatric population. Additionally, as discussed in Appendix B., the prevalence of BH conditions amongst the pediatric populations in Montana is particularly high, making pediatric programming even more relevant to study.

Analysis to inform understanding of pediatric BH in Montana involved data analytics, qualitative research, and stakeholder input. In addition to committee meetings that engaged both pediatric and adult experts from across the State throughout the project, the study team held additional interviews with program experts and leaders in the State for pediatric BH, child welfare, and pediatric patients with co-occurring disorders, such as I/DD, SUD, or BH diagnoses.

The compilation of the above analytical sources allowed for alignment of the recommendations found in the main body of this report with key priorities identified for the pediatric population in Montana that have BH diagnoses.

Primary Recommendations for the Pediatric Population

Click on the link, **Recommendation 1.2. Enhance existing infrastructure and resources – for example CCBHC, mobile crisis, PACT/ACT, school-based programs with sustained funding**. or see details on page 21.

Click on the link, **Recommendation 2.3. Increase capacity of in-state residential treatment and group homes for the pediatric population** to reduce out-of-state , or see details on page 49.

Secondary Recommendations for the Pediatric Population

1. Continuum of Care

Develop a statewide comprehensive care management role or entity to facilitate care coordination between participants in Montana's system.

Offer Comprehensive Pediatric Care Management: Provide care coordination services for parents and caregivers to facilitate continuity across settings and prepare for developmentally appropriate and step-down/step-up acuity transitions. Offer families and caregivers the opportunity to have a single resource for an extended period to work with and coordinate necessary care, who is also familiar with their experiences and needs. To avoid duplication of services and payment for case management services, individuals receiving Medicaid TCM would not be eligible to receive services from the comprehensive care manager role or entity. For further description of the operational details related to this recommendation, please refer to Recommendation 1.1 in the main body of the report.

Expand the use of integrated behavioral care models to support collaboration through partnerships with primary care and BH providers, enhanced reimbursement, and training.

Expand Integrated Behavioral Care for the Pediatric Population: Provide broader access to pediatric BH services, particularly in rural and frontier areas, through partnerships with primary care practices interested in integrating BH providers. Offer training that addresses the unique aspects of identifying and addressing BH conditions in the pediatric population at different

developmental stages. Evaluate feasibility of increasing reimbursement for primary care providers and BH specialists providing integrated BH and I/DD services in rural and frontier areas to incentivize treating more pediatric patients with Medicaid coverage, regardless of co-occurring disorders or perceived case complexity. Provide ancillary support providers with training to identify and treat or refer individuals with complex conditions to specialists for additional care.

Promote increase in use of telehealth, telemedicine, and telepsychiatry for appropriate cases.

Increase Utilization for Telehealth, Telemedicine, and Telepsychiatry Services for Lower Acuity and Maintenance Services for the Pediatric Population: Promote the increased usage of telehealth services in schools and via mobile units to bring care to where the pediatric population are consistently present and transportation to appointments is not a barrier. Services that would not be appropriate for telehealth would include those for pediatrics who are young or with certain diagnoses such as bipolar, schizophrenia, autism, or with major isolation disorders. Tele-services will also be an effective way to bring care to the pediatric population and their families via mobile vans to provide family and group counseling in rural and frontier areas.

Continue and expand commitment to BH-focused public education campaigns.

Expand Commitment to Pediatric BH-focused Public Education Campaigns: Increase education regarding BH condition recognition, awareness of existing resources, and highlighting resources available to access pediatric services. Discuss both preventative services to maintain wellness and overall treatment options available. Include information regarding family and caregiver support resources and community opportunities.

2. Access

Expand community-based crisis receiving and stabilization centers.

As a part of expanding crisis receiving and stabilization centers across the State, pediatric populations should remain a strong consideration as facilities are designed and staffed. Currently, Montana does not have licensure standards for crisis and stabilization for those individuals under the age of eighteen. To offer pediatric crisis receiving and stabilization centers, licensure would need to be drafted, so facilities could receive pediatric patients. Depending on anticipated need, consider the creation of a pediatric pod or developmentally appropriate space for the pediatric population seeking crisis care.

Enhance access to Comprehensive Behavioral Healthcare Campuses, especially in the east to improve transitions between inpatient, sub-acute, and OP care.

Enhance Pediatric Access to Comprehensive Behavioral Healthcare Campuses: Providing appropriate levels of care for the pediatric population closer to home ranging from OP to sub-acute to IP, allows for increased caregiver and family involvement and treatment, potential for increased program customization based on clinical need, and less disruption to patients' and families' daily schedules. Developing familiarity with one facility and its staff, or several facilities nearby, results in increased comfort levels with accessing care and heightened awareness of where to seek help when needed. Additionally, it allows the facilities to share staff at times and optimize services provided making better use of scarce resources. At a state level, mid-acuity services and introducing innovative service settings, such as Comprehensive Behavioral

Healthcare Campuses, has the potential to fill significant pediatric BH service gaps, reinforced in data analytics and stakeholder interviews.

3. Workforce

Create dedicated provider recruitment / retention unit within state government to support expansion and maintenance of homegrown BH workforce.

Expand and Maintain a Pediatric Homegrown BH workforce: Allocate recruitment resources to identify and recruit pediatric BH providers for greatest need regions in Montana. Outline for high school, community college, and university students' opportunities in providing behavioral healthcare to the pediatric population focusing on grants, loan forgiveness, and scholarship opportunities for working in rural and frontier areas, highlighting the Montana lifestyle, and community give-back.

To accomplish this task, the study team recommends that the State conduct a needs assessment to evaluate existing BH recruitment and retention activities within and outside of the State. This exercise would lead to a strategic implementation and the determination of the appropriate entity to oversee a focused recruitment initiative. The initiative may best be managed by either an existing or new governmental unit or through a third-party. If a third-party, the third-party contractor, identified through a procurement process, would hire Behavioral Health Recruitment and Retention Specialists, and establish a dedicated BH Recruitment and Retention unit.

Evaluate the sustainability of expanding the scope and/or use of ancillary providers (e.g., peer support specialists, community health workers, family caregivers) to deliver BH-related services and integrate these providers into BH care teams.

Expand pediatric scope of practice for ancillary providers to integrate into behavioral healthcare teams: Enhance training and support for pediatric-focused peer support specialists, community health workers, and family caregivers can provide BH support services as an integral part of the BH team. Overall, create clinical policy and procedures that encourage provider practice to their highest licensed capabilities to optimize the workforce and support underserved populations, including the pediatric population.

Expand training for traditional and ancillary BH workforce to optimize their scope of practice to support community behavioral healthcare.

Build on existing education initiatives (e.g., universities, residencies, and fellowships): Develop public-private partnership with universities, colleges, and junior colleges to develop coursework to address pediatric and family-related BH issues in subjects such as family and historical trauma, positive family dynamics, addressing difficulties with raising children with BH problems, and the unique aspects of diagnosing and treating the pediatric population at different life stages.

Appendix H. Subcommittee and Steering Committee Members

Steering Committee Members

Table 59 lists Steering Committee members.

Table 59. Steering Committee Members

Name	Representing
Dr. Eric Arzubi	Frontier Psychiatry
Rep. Michele Binkley	House Republican – 872 Commission
Sen. Ellie Boldman	Senate Democrat – 872 Commission
JJ Carmody	Billings Clinic
Elizbeth Cumming	Constituent
Sen. John Esp	Senate Republican – 872 Commission
Bernie Franks	Disability Rights Montana
Rep. Dave Fern	House Democrat – 872 Commission
Rachel Green	Governor's Office
Nicole Jemming	The Springs
Rep. Bob Keenan	House Republican – 872 Commission
Matt Kuntz	National Alliance on Mental Illness – Montana
Anna Lange	Montana Healthcare Foundation
Janet Lindow	Rural Behavioral Health Institute – 872 Commission
Patrick Maddison	MACDS/Flathead Industries – 872 Commission
Scott Malloy	Montana Healthcare Foundation
Dr. David Mark	One Health
Thomas McGuire	St. Patrick Hospital
Duane Preshinger	Montana Hospital Association
Cindy Stergar	Montana Primary Care Association
Deborah Swingley	Montana Council on Developmental Disabilities
Cherie Taylor	Logan Health
Aaron Wernham	Montana Healthcare Foundation
Lea Wetzel	Constituent
Mary Windecker	Behavioral Health Alliance of Montana
Rep. Mike Yakawich	House Republican – 872 Commission

Subcommittee Members

Table 60 lists Steering Committee members.

Table 60. Subcommittee Members

Name	Representing
Craig Aasved	Shodair
Jill Alessi	Mountain Pacific Quality Health
Dr. Eric Arzubi	Frontier Psychiatry
Aaron Atkinson	The Arc
Beth Ayers	Constituent
Dwight Badger	Recovery Centers of Montana
Chris Baglio	Intensive Behavioral Center
Jenni Baily	Constituent
Trista Besich	Alluvion Health
Rep. Michele Binkley	House Republican – 872 Commission
Sydney Blair	Many Rivers Whole Health
Ben Bledsoe	Consumer Direct Care Network
Cassidy Blomgrin	Alluvion Health
Phoebe Blount	Fort Peck
Sen. Ellie Boldman	Senate Democrat – 872 Commission
Steve Bolstad	Municipal Court Judge – Mental Health Court
Jean Branscum	Montana Medical Association
Dawna Brinkel	Home Care Montana
Melissa Brock	Intensive Behavioral Center
Katherine Buckley Patton	Western Service Area Authority
Matt Bugni	Aware
David Carlson	Disability Rights Montana
JJ Carmody	Billings Clinic
Sarah Chapman	Constituent
Mike Chavers	Yellowstone Boys & Girls Ranch
Jeromy Christiansen	Fort Peck
Kessalyn Clark	Helena Indian Alliance
Brenda Connelly	The Springs

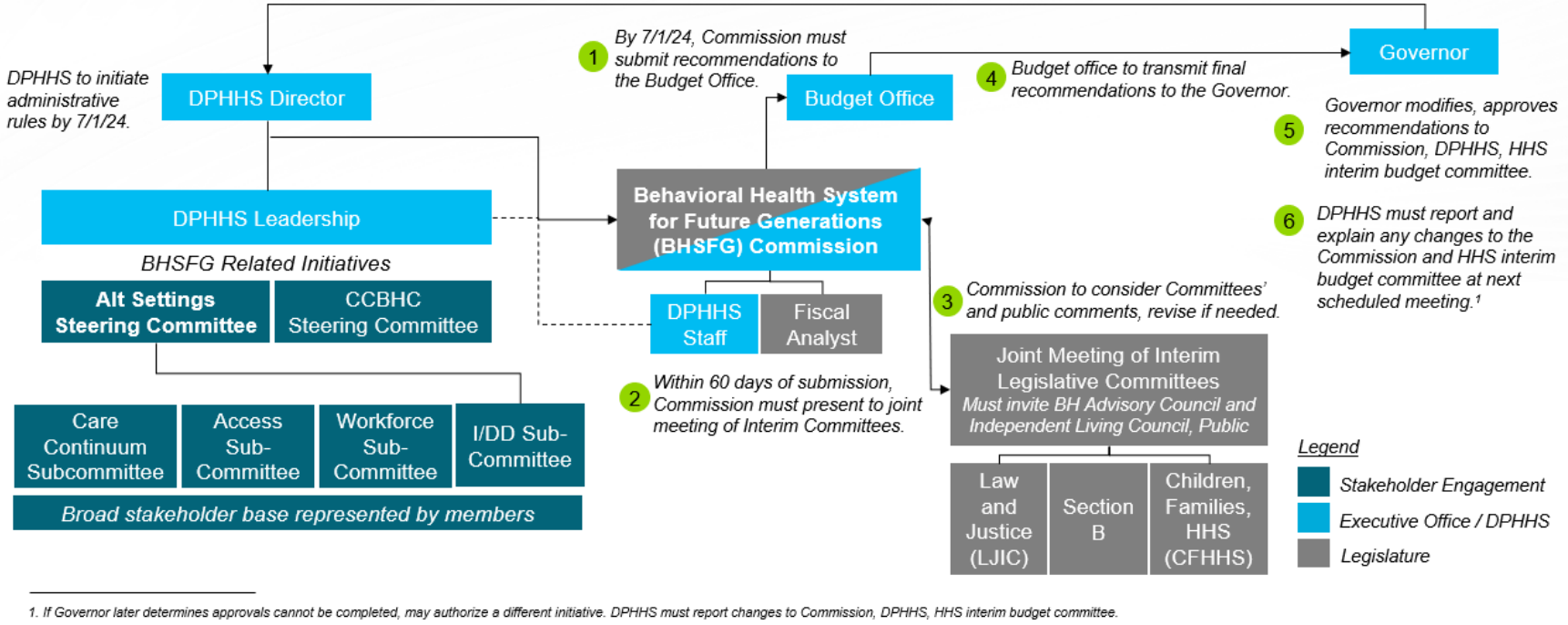
Name	Representing
David Culbertson	Montana State Hospital
Elizbeth Cumming	Constituent
Isaiah Devereaux	Constituent
Shari Dolan	Logan Health
Jim Duncan	Billings Clinic
Dr. Heidi Duncan	Billings Clinic
Michelle Eliason	Milk River
Sen. John Esp	Senate Republican – 872 Commission
Debbie Essert	Rocky Boys Indian Health
Scott Eychner	Rehabilitation and Programs Division – Department of Correction
Rep. Dave Fern	House Democrat – 872 Commission
Julie Fink	Office of Inspector General
Jeff Folsom	University of Montana
Dr. Desiree Fox	Confederated Salish & Kootenai Tribal Health
Bernie Franks	Disability Rights Montana
Jess Fuhrman	Eastern Montana Community Mental Health Center
Ann Geiger	Liberty Place
Jessica Gilbert	Behavioral Health Advisory Council
Nanette Gilbertson	Montana Sheriffs & Peace Officers Association
Brian Gootkin	Director Department of Corrections
Rachel Green	Governor's Office
Aaron Grossman	Constituent
Jim Hajny	Montana Peer Support Network
Shawna Hanson	The Rural Institute for Inclusive Communities
Dr. Douglas Harrington	Medical Director – Department of Public Health and Human Services
Jeremy Hoscheid	Montana Mental Disabilities Board of Visitors
Jenna Huey	Human Resource Development Council
Chris Hughes	Bitterroot School District
Carla Hunsley	Constituent
Nicole Jemming	The Springs
Kyle Johnson	Helena Indian Alliance
Rep. Bob Keenan	House Republican – 872 Commission

Name	Representing
Matt Kelly	Montana Public Health Institute
Josh Kendrick	The Arc
Molly Kimmel	Rural Institute for Inclusive Communities
Brenda Kneeland	Eastern Montana Community Mental Health Center
Leighann Knight	Aware
Dave Krebs	Benefis
Carrie Krepps	Florence Crittenton
Matt Kuntz	National Alliance on Mental Illness – Montana
Vanessa LaBarge	Indian Family Health Clinic
Crystal Laufer	Central Service Area Authority
Claire Leonard	Constituent
Virginia Lindauer	North West Home Care
Janet Lindow	Rural Behavioral Health Institute – 872 Commission
Sami Lodahl	Constituent
Lois Macias	Western Montana Mental Health Center
Nicole Madden	Bozeman Health Deaconess
Patrick Maddison	MACDS/Flathead Industries – 872 Commission
Christian Madison	Indian Family Health Center
Andy Malby	Constituent
Dr. David Mark	One Health
Brenda McGaha	Elkhorn Healthcare & Rehabilitation
Thomas McGuire	St. Patrick Hospital
Teresa McKeon	Constituent
Kailyn Mock	Montana State University
Jean Morgan	Spring Meadow Resources
Brent Morris	Eastern Service Area Authority
Dr. Sharon Mulvehill	ASAM Expert/Rimrock
Jackie Myers	Rocky Boys Indian Health
Babak Nayeri	Indian Health Services
Heather O'Hara	Montana Hospital Association
Michael O'Neil	Helena Housing Authority
Bob Olsen	Montana Hospital Association

Name	Representing
Alan Ostby	Indian Health Services
Dana Paulson	Overture
Joel Peden	Centers for Independent Living
Kaia Peterson	Neighborworks
John Petroff	Missoula Fire Department
Duane Preshinger	Montana Hospital Association
Chris Quigly	Montana Sex Offender Treatment Association
Diane Rafferty	Montana State Nursing Home
Cecily Raining Bird	Constituent
Thomas Risberg	Constituent
Eden Roberts	Chief Safety Officer – Child and Family Services Division
Kristi Rowell	Glacier Care Center
Davonna Ryan	Montana Chemical Dependency Center
Lara Salazar	Partnership Health Center
Capt. John Schaffer	Great Falls Police Department
April Seat	Constituent
Savanah Sith	Centers for Independent Living
Nathan Stahley	National Association of Social Workers – Montana
Randy Stephens	Planning Manager – Architecture and Engineering
Cindy Stergar	Montana Primary Care Association
Jackie Stewart	Crow Indian Health Services
Deborah Swingley	Montana Council on Developmental Disabilities
Diana Tavary	Constituent
Cherie Taylor	Logan Health
Greg Tilton	Constituent
Anne Titus	Benchmark
Terri Todd	Gratitude in Action
Ben Uhlich	Holy Rosery
Roy Valdez	Department of Labor and Industry
Angela Wathan	Constituent
Rob Watson	Montana Association of School Superintendents
Aaron Wernham	Montana Healthcare Foundation

Name	Representing
Lea Wetzel	Constituent
Janessa White	Consumer Direct Care Network
Jennifer Whitfield	Many Rivers Whole Health
Jeremy Williams	St. Patrick Hospital
Theresa Williams	CIT Program Manager
Danthony Willis	Constituent
Mary Windecker	Behavioral Health Alliance of Montana
Cynthia Wolken	Deputy Director – Department of Corrections
Rep. Mike Yakawich	House Republican – 872 Commission

Appendix I. BHSFG Initiative and Recommendation Approval Process



1. If Governor later determines approvals cannot be completed, may authorize a different initiative. DPHHS must report changes to Commission, DPHHS, HHS interim budget committee.

Figure 62. BHSFG Initiative and Recommendation Approval Process