Montana's Rural Health Plan 2021

Montana Department of Public Health & Human Services (DPHHS)
Office of Inspector General (OIG)
P.O. Box 202953
2401 Colonial Drive
Helena, MT 59620-2953
www.dphhs.mt.gov/qad

Acknowledgement

There are roughly 1.1 million people living in Montana and 695,000 who call rural Montana home. That is approximately 63% of the state's population that live and work in small towns, farms and ranches of Montana. The Montana Rural Health Plan attempts to describe the health care situation for this unique portion of our state's citizens. As rural health advocates, the Montana Rural Health Plan Task Force knows that what works for urban folks does not necessarily work for rural counterparts. Rural Montana is unique and therefore requires unique approaches to today's health care challenges. We would like to acknowledge all those who deliver health care in rural Montana and their willingness to take what limited resources they have and employ them to serve the needs of their communities.

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $806,474 with 0% financed with non-governmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Table of Contents

List of Tables, Graphs and Maps

Tables **Page**

Graphs

Maps

Purpose of Montana's Rural Health Plan

The primary purpose of *Montana's Rural Health Plan* is to guide Montana's Critical Access Hospital (CAH) program and future Rural Hospital Flexibility (Flex) Program grant expenditures. This document is also intended for use by other rural, Montana health care stakeholders to assist them in the work they do.

The purpose of the Montana Rural Health Plan for 2021 should be expanded from the above stated purpose due to the following factors:

- The 2011 State Rural Health Plan (SRHP) is terminally outdated and no longer relevant. For example, the population of Montana now a bit over 1 million, and is almost 350,000 more than lived here in 2011.
- Of the 66 licensed hospitals in Montana, 74% (49) are Critical Access Hospitals
- Of the 1,340 CAHs in the United States, only 248 bring in less than $10 million annually in Net Patient Revenue (NPR). Montana has 24 of them.
- In the last decade, over 100 rural hospitals have closed. Montana has not had a single closure…. yet.
- The population density definitions for Urban, Rural and Frontier from the 2011 version of the SRHP list only one county as "Urban". Only 10 of our counties, all of which include the largest communities, are listed as rural (less than 50 people per square mile.) The remaining 45 counties are listed as "Frontier" (less than 6 people per square mile). Subsequently, almost the entire geography of Montana is by Federal definition, "Frontier". Very few states are as frontier as Montana.
- A key initiative of the Public Health System Improvement Office and the Public Health System Improvement Task Force (the parent entity of the State Health Improvement Coalition) is development of the statewide public health workforce, now reeling from the COVID-19 pandemic.
- EMS, identified as one of 6 focus areas in the 2011 SRHP, was described then in "serious condition". The state of EMS in Montana in 2020 is now a crisis and getting worse. Aging volunteer workforce, lack of funding for paid workforce and ongoing reimbursement reductions are creating potential situations in parts of Montana where there will be no one to respond to 911 calls.
- The COVID-19 pandemic has forever changed the frontier healthcare landscape. Supply chain issues, loss of elective services revenue, workforce concerns, distance from larger hospitals, and lack of providers have all forced massive review of policies and procedures in consideration of the next pandemic, even while this one continues.
- The distance between hospitals, the difficulty tiny CAHs experience in struggling to keep the doors open, the increasing pressure to provide "value-based care", the difficulty in recruiting providers to frontier communities, and the increasingly aged population all indicate that when/if Montana begins closing frontier facilities, Montanans who live in frontier communities will begin dying of things that people in larger communities don't die from. Already, diminishing services in remote CAHs have resulted in complete lack of obstetric (OB) services for all but a handful of small communities, with resulting inconvenience (at best) and sometimes risk or fatality for mothers and babies.

- The COVID-19 pandemic has resulted in Telehealth moving from an "honorable mention" in the 2011 SRHP, to an essential service, especially for frontier Montana communities, and is given increased prominence and attention in the 2021 SRHP.

The COVID-19 Pandemic

Montanans began to learn about, and be impacted by, the outbreak of COVID-19 in early March 2020. The emergence of a new virus to which humans had limited immune response caused a number of significant impacts to the delivery of health services, the operations and policy formulation of state and local health departments and drastic reductions to commerce. Montanans were urged to don face masks, wash their hands frequently, avoid unnecessary travel and practice social distancing as the most reliable response available to combat the spread of the virus.

Along the way, the public reaction to the new virus became politicized. A number of people resisted the messaging from health officials, claiming the restrictions imposed illegal constraints on personal freedoms and individual rights. But elderly people and those with significant health risks and weakened immune systems were at risk for significant health impairment and death due to infection by the new virus.

This SRHP project also suffered as employees faced travel restrictions, were required to work remotely when possible and to avoid working in groups absent CDC health protocols. The stakeholder group was not able to come together and engage in robust conversations with one another, nor to put aside immediate crisis-management activities in order to engage in meaningful conversations about rural health policy or future trends to address in a forward-thinking plan.

As the months rolled by during 2020, Montana health providers were inundated with emergency and intensive care protocols required to address COVID-19 cases. Most services considered to be optional were put off in order to preserve access to more acute care. Health providers and the public suffered from a lack of all types of protective equipment needed to provide the best care or to meet the most basic requirements of social reaction to the pandemic. Grocery stores, for example, ran short of most personal health products, toilet paper and meat. Things as basic as hand sanitizer became hard to find.

As we enter the third quarter of 2021 there is perhaps a feeling that the worst of this pandemic is behind us. There are new vaccines and protective equipment becoming increasingly available and consumer products are not in short supply. There is increasing economic activity and more people are returning to work, and to working inside their employers' businesses.

It is not too soon to begin to catalog the challenges posed to rural health care by the pandemic. Additionally, the Montana legislature amended long-standing public health laws in order to limit the authority of local health authorities in deference to elected officials. Initially, some rural counties claimed that local control of health policy in reaction to pandemic should prevail over state action ordered by the Governor; following the 2020 election, the focus has now shifted to deny access to federal recovery funds if local policies exceed those ordered by the state.

There will be a need to evaluate the response to this pandemic and the public health emergency it created. Rural providers may wish to engage in planning exercises and take other steps necessary to better respond to public health emergencies.

Table 1: Montana COVID-19 Dashboard July 14, 2021

Reported Cases	Totals
Montana	**114,508**
Active Cases	465
Recovered	112,360
Hospitalizations	5,576
Deaths	1,683
United States	**33,951,558**

Vaccinations	Totals
Montana Vaccinations Administered	876,755
United States Vaccinations Administered	334,328,144

Source: Montana COVID-19 Dashboard

The Medicare Rural Hospital Flexibility (Flex) Program

The Medicare Rural Hospital Flexibility (Flex) Program was created by the Balanced Budget Act (BBA) in 1997. The model had been developed by staff from the Federal Health Resources and Services Administration (HRSA) with significant input and advocacy by the Montana Hospital Association and Sen. Max Baucus following the implementation of the Medical Assistance Facility (MAF). MAF was the precursor to the Critical Access Hospital (CAH) designation, also heavily championed by the Montana Hospital Association and its member hospitals. The Flex Program was developed specifically to support the activities of the newly converted CAH facilities. Revisions occurred through the Balanced Budget Refinement Act (BBRA); the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA); the Medicare Prescription Drug, Improvement and Modernization Act (MMA); and the Patient Protection and Affordable Care Act (PPACA). The Flex Program is intended to preserve access to primary and emergency health care services, improve the quality of rural health services, provide services that meet community needs and foster a health delivery system that is both efficient and effective. In addition, the Flex Program specifically supports the designation of critical access hospitals (CAHs).

To accomplish the intent of the Flex Program, federal resources have been made available to state-appointed designees (commonly within state offices of rural health) to support CAHs by implementing the Flex Program in their state. States administer the Flex Program and apply to the Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy (FORHP), for federal Flex Program funding. Additional federally funded resources to support Flex include the Technical Assistance and Services Center (TASC) to provide technical support to states for program implementation, Rural Quality Improvement Technical Assistance (RQITA) to provide technical support to the Medicare Beneficiary Quality Improvement Project (MBQIP) and the Flex Monitoring Team (FMT) to evaluate overall Flex program impact.

The Flex Program contains a special project, MBQIP, which focuses on improving the

quality of care that CAHs provide. CAHs that wish to participate in Flex-funded activities must participate in, and report on, MBQIP core quality measures. MBQIP eligibility information is assessed annually by FORHP when outcome data is available.

For the current funding cycle, Fiscal Years (FYs) 2019-2023, the primary components of the Flex Program include activities in the following program areas:

- CAH Quality Improvement (required)
- CAH Operational and Financial Improvement (required)
- CAH Population Health Improvement (optional)
- Rural Emergency Medical Services Improvement (optional)
- Innovative Model Development (optional)
- CAH Designation (required if requested by eligible facilities)

The Montana Flex program, comprised of a partnership between the DPHHS Office of Inspector General and the Montana Hospital Association's Foundation, the Montana Health Research & Education Foundation, focuses its scope of work primarily in the first three program areas: Quality Improvement, Financial & Operational Improvement, and Population Health Improvement. Montana Flex also works closely with DPHHS Public Health & Safety Division Emergency Medical Services and Trauma Systems (EMSTS) to execute the Rural Emergency Medical Services (EMS) Improvement and Financial & Operational Improvement components of the Flex program as well as the Chronic Disease Prevention and Health Promotion Bureau for activities in the Population Health Improvement area.

The Montana Flex Program continues to encourage the identification of areas for improvement with defined targets and measurable outcomes. A minimum standard of reporting on outcomes is requested for all state Flex Programs.

Section 1: Montana's Health Demographics

Geography

Montana is geographically the fourth largest state (147,040 square miles), ranking behind Alaska, Texas and California in total area.[1] It is 630 miles east to west and 255 miles north to south; Montana's northern border is shared with three Canadian provinces (more than any other state) and is bordered to the east, south and west by the states of North Dakota, Wyoming and Idaho. It takes nine hours (without stopping) to drive across the state at 70 miles per hour on an Interstate highway, longer if traveling on one of Montana's many two-lane roads. The designated frontier areas of Montana contain 133,133 square miles, 90 percent of the state's total area.

Map 1 shows the State of Montana overlaid on a U.S. map. The map clearly shows Montana's large size, taking up a good portion of the land mass in the eastern United States. The size of Montana from west to east is approximately the same distance as traveling from Chicago, IL to Washington, DC. The size of Montana from north to south is the same distance as traveling from the Great Lakes to Tennessee.

Thirty-five per cent (35%), or 31 million acres of land within Montana is public land held by federal, state or local governments. Public land includes several wilderness areas, federal and state forests, Bureau of Land Management grazing lands and other school

lands.[2]

The size, and the considerable swaths of public and roadless land in the state, pose clear challenges to transportation and access for all industries – but particularly for healthcare, where time to care is often the difference between life and death. The state's sparsely distributed population, discussed below, compounds this problem.

Census

Although 2020 was a year in which the US Census Bureau conducted its 10-year census, the data from that effort was not available at the time of this report. Montana's population did climb above 1 million residents, and a second Congressional District was awarded to the State. Future discussions about rural health care should review the new census data when available, and to consider the implications of a second member of Congress on rural health policy.[3]

Of the 56 counties in the state, 45 are considered frontier based on having population densities of less than 6 persons per square mile. Montana's one urban county (Yellowstone), as well as its 45 frontier and 10 rural counties, are listed in Table 2 along with population densities for each county, comparing 2010 to 2019. The 2019 estimated population of Montana was 1,068,778, putting the overall population density at 7.27 per square mile for the state. Map 2 shows Montana counties by designation. This document uses the U.S. Census Bureau's population density definitions; however, it is important to note that there are many differing definitions for urban, rural and frontier.[4]

Montana has 129 incorporated cities and towns, ranging in size from Billings (109,595) to Ismay (25). There are only seven cities and towns (Billings, Missoula, Great Falls, Bozeman, Helena, Butte, Kalispell) with populations above 20,000 and there are no communities with populations between 10,000 and 20,000. This means that the remaining 122 incorporated communities are very small, with populations ranging from a high of 9,656 to a low of 25. 74 of Montana's 122 small communities have populations below 1,000.

Montana is the oldest state west of the Mississippi, according to median age statistics from the U.S. Census Bureau. With half the state's population 40 or older, we're the 9th oldest in the nation, out-grayed only by Florida, Maine, and a few other eastern states. Peak age is yet to come, according to demographic projections produced for the state Department of Commerce by consulting firm REMI. As of 2017, the baseline year used by those projections, 18% of Montanans were 65 or older, up from 14% in 2001. The figure is expected to climb to 22% by 2030, then plateau through 2040 as boomers reach the end of their lives.[5]

From a health care perspective, the Washington-Wyoming-Alaska-Montana-Idaho (WWAMI) Rural Health Research Center describes frontier as a "subset of rural that has different health care delivery system... needs because they [small cities and towns] are remote from large cities and towns (e.g., most of Alaska and Montana)". This rural health concept can be objectively defined by six or fewer persons per square mile for whole counties. Counties defined as urban have more than 50 persons per square mile, while rural counties have fewer than 50 persons, but more than 6 persons per square mile. Frontier counties are those that have 6 or fewer persons per square mile.

Montana's Native Americans count for 6.7%, or 71,608 persons in the 2019 census data.[6] There are eight federally recognized tribes in Montana and distribution can be seen on Map 3. There are three hospitals in the state that are classified as Indian Health Services (IHS), located in the communities of Browning, Crow Agency and Harlem. The Fort Belknap Health Center in Harlem was the first Indian Health Service critical access hospital in the nation.

Montana increased in population from 989,415 in 2010 to 1,068,777 in 2019, an 8% increase over ten years. Thirty-two of the 56 counties have gained population, 18 remained the same, and just 6 counties lost population. Even as population increased, the distribution of the increase is skewed toward already more populous counties. Montana remains a mostly frontier state, where access to health care is impacted by proximity and distance to rural and urban counties.

Montana has a long history of innovation and finding creative solutions to its rural health care challenges. In 1989, in response to the challenge of rural Montana health care facilities facing closure and rural Montanans losing access to medical care, the idea of a Medical Assistance Facility (MAF) was born. Twenty-three MAFs were the model for the current federal Critical Access Hospital (CAH) program, which was developed and piloted by Montanans. The CAH program has now grown to 49 hospitals in the state and 1,343 across the U.S. Maps 4 and
5 represent where CAH facilities are located within the state and U.S.

Looking to the future, the significant aging of Montana's citizens is of particular concern to health care decision and policy makers.

It is reasonable to expect the current demographic trends to continue in Montana into the near future. This means there is likely to be a relatively slow rate of growth, with larger population centers increasing most and smaller, more remote communities growing less. Montana is likely to see continued aging of the overall population.

Table 2: Montana Population Density by County

Urban (1 county)	Persons per square mile in 2010	Persons per square mile in 2019
Yellowstone	54.9	57.9

Rural (10 counties)	Persons per square mile in 2010	Persons per square mile in 2019
Silver Bow	45.9	47.9
Missoula	41.8	42.8
Gallatin	34.7	35.4
Lake	19.1	17.5
Flathead	17.6	17.6
Lewis & Clark	17.9	18.5
Cascade	30.5	30.2
Ravalli	16.9	16.9
Deer Lodge	11.9	12.5
Jefferson	6.9	6.9

Frontier (45 counties)	Persons per square mile in 2010	Persons per square mile in 2019
Hill	5.7	5.6
Park	5.7	5.6
Lincoln	5.2	5.3
Stillwater	4.9	5.1
Carbon	4.8	4.9
Richland	4.5	5.1
Roosevelt	4.4	4.6
Sanders	4.0	4.1
Dawson	3.6	3.9
Broadwater	4.0	4.6
Glacier	4.5	4.5
Pondera	3.6	3.8
Mineral	3.1	3.5
Powell	3.0	3.0
Custer	3.0	3.1
Toole	2.7	2.7
Big Horn	2.6	2.6
Fergus	2.6	2.6
Teton	2.7	2.6
Musselshell	2.5	2.5
Madison	2.1	2.1
Sheridan	1.9	2.1
Fallon	1.7	1.9
Rosebud	1.8	1.9
Sweet Grass	2.0	1.9
Granite	1.7	1.8
Beaverhead	1.6	1.7
Blaine	1.5	1.6
Choteau	1.3	1.5
Liberty	1.2	1.5
Valley	1.4	1.5
Wheatland	1.4	1.5
Daniels	1.2	1.3
Judith Basin	1.1	1.1
Wibaux	1.0	1.1
Meagher	0.8	0.8
Phillips	0.8	0.8
Treasure	0.6	0.8
McCone	0.6	0.7
Prairie	0.6	0.7
Golden Valley	0.9	0.6
Powder River	0.5	0.5
Carter	0.4	0.4
Petroleum	0.3	0.3
Garfield	0.3	0.2

Montana's Access Barriers

One Montana Critical Access Hospital CEOs always began medical provider recruiting conversations with, "Our town is 70 miles from the nearest McDonald's, 90 miles from the nearest Wal-Mart and 200 miles from the nearest shopping center. Can you handle that?" This description of an isolated Montana community is not unusual. A former Montana U.S. Senator put it this way, "There's a lot of dirt between light bulbs in Montana."[7] Geographic isolation and the long distances between towns and health care organizations are often barriers to health care access in Montana.

Table 3: Distance from Select Rural & Frontier Communities to Urban Areas

Communities	Scobey to Billings	Glasgow to Billings	Ekalaka to Billings	Malta to Billings	Libby to Missoula	Ennis to Missoula	Dillon to Missoula	Cut Bank to Great Falls
Interstate Route	363 miles	276.9 miles	260 miles	238 miles	211 miles	206 miles	180 miles	109 miles
MT 200 Route	357.9 miles	305 miles			193 miles			

Distances calculated using Mapquest.com. Routes are Interstate unless otherwise indicated.[8]

A special survey completed in 2005 found that 54% percent of Montanans travel more than five miles each way to get to a doctor's office; 13% travel more than 30 miles; 7% travel more than 50 miles.[9] With little or no public transportation available in many of Montana's isolated, rural communities, access to local primary care as well as out-of-town specialty medical services is a problem. Nearly 96% of Montanans drive themselves or get a ride from a friend when traveling to a doctor's office; less than 1% use public transportation because public transportation is found primarily in urban areas. Little has changed since that 2005 survey.

The Department of Veterans Affairs provides health services and benefits to active or retired service men and women and their families. The Rocky Mountain Network provides health services for a four-state area (MT, WY, UT, CO) and has VA Health Care Systems in Denver, Colorado, Salt Lake City, Utah and Fort Harrison (Helena), Montana.[10] There are multiple outpatient clinics, Veterans' Centers, and Community-based Outpatient Centers (CBOCs) located throughout Montana that provide care on an outpatient basis, but only the VA Montana Health Care System located in the capital city provides inpatient treatment. Long distances can make access difficult for individuals needing inpatient care, and for older veterans, a long car trip is often uncomfortable and time consuming.

The VA Mission Act of 2018 aimed to address both distance and delayed access to primary and tertiary care for veterans. Two provisions of the Act provide for access to local, non-VA clinic and hospital providers for emergency and urgent care. A third provision created the community care network benefit that allows veterans, with prior approval, to access local non-VA community providers if the veteran must travel 30 minutes for primary care or 60 minutes for specialty care, or if, the veteran faces a considerable delayed access to appointments with VA providers.[11]

The isolation, low population densities and long travel distances in Montana affect all aspects of our citizens' lives, including health care. Montana is a rural state and, as demonstrated in data above, is in fact a "frontier" state.
Planning must be based not just on strategies and resources developed for rural areas, but for vast expanses that transcend rurality. Future planners and health policy developers must always consider these consistent barriers to access when deliberating new policies and programs.

Health Status Indicators

Health status indicators help to monitor and rate the population and are an important aspect of health care. Montana ranked 25th in 2018.[12] Montana's strengths include a low prevalence of obesity at 28.3 percent, a high prevalence of exercise, and a high percentage of volunteerism. Table 4 shows how Montanans compared with the U.S. in percentages of total deaths. In 2018, Montana's teen death rates were 68 per 100,000 compared to 52 for the U.S., but infant mortality rates were at 4.8, which is just slightly lower than the U.S. rate of 5.7 per 1,000 live births. Montana's overweight or obese children account for 27.6% compared to the higher U.S. rate of 30.7%. Montana continues to suffer from one of the nation's highest rates of suicide per 100,000 population, at 24.9 versus just 14.2 for the U.S. as a whole.

The Montana State Health Improvement Plan (SHIP) is a collaborative vision for a healthier Montana that monitors key health indicators that address five shared health priority areas: 1) behavioral health, 2) chronic disease prevention and self-management, 3) motor vehicle crashes, 4) healthy mothers, babies, and youth, and 5) adverse childhood experiences. Reports are published annually tracking these key health status indicators and can be found on the A Healthier Montana DPHHS website: https://dphhs.mt.gov/ahealthiermontana.

The SHIP is developed using the Community Health Needs Assessments and Implementation Plans produced by hospitals across the state, as well as the similar plans completed by health departments. The key health priorities of communities are analyzed and consolidated into a comprehensive planning document as a resource for the state.

According to America's Health Rankings 2018, Montana faces significant challenges due to a high prevalence of excessive drinking, drug use, adult smoking rates, and a lower-than-average immunization rate. Montana also faces greater barriers to behavioral health treatment (including both the issues of distance and access discussed above, and workforce shortages, examined in Section2).

On a positive note, Montana has greatly improved worker safety over the past two decades. The rate of occupational fatalities decreased by 79% between 1990-1992 and 2016-2018 from 27.8 to 5.9 deaths per 100,000 workers.[13]

As noted above, 1683 Montanans died from COVID-19. Future review of this plan should consider Montana's mortality rate due to the pandemic, and determine what, if any public health considerations are required to address this issue.

Table 4: Top 10 Causes of Death – Montana & U.S. Comparison

Cause of Death	Heart Disease	Cancer	Chronic Lower Respiratory Disease	Accidents	Cerebrovascular Disease	Alzheimer's Disease	Diabetes	Chronic Liver Disease / Cirrhosis	Pneumonia / Influenza	Suicide
Montana % 2007	21.7	22.3	7.0	7.1	7.0	3.0	3.0	1.6	2.1	2.3
Montana % 2015	24.7*	21.7	6.6*	5.5*	5.1	3.6	2.5	2.5*	2.2*	1.8*
U.S. % 2015	23.4	22	5.7	5.4	5.2	4.1	2.9	1.8	2.1	1.6

Death rates percent of total deaths. Montana rates higher than the national average are marked with an asterisk (*)

Table 5 shows that Montana's overweight or obese children ages 10-17 accounts for 25% compared to the higher U.S. rate of 31.2%.[14] Montana continues to suffer from one of the nation's highest rates of suicide per 100,000 population, at 29.8 versus just 13.9 for the U.S. as a whole.

Montana has a mixed experience with health rankings compared to national measures and must improve to meet the targets established in Healthy People 2030.[15]

Table 5: Five Key Health Indicators for Montana and U.S. including Healthy People 2030

Health Indicator	Suicide	High Blood Pressure	Obesity	Smoking	Diabetes
Montana	29.8 per 100,000 people (2019)	29.5% adults (2019)	25% age 10-17 (2019)	16.6 % adults (2019)	9.3% adults* (2018)
U.S. Rate (Year)	13.9 per 100,000 people (2019)	29.5 % adults (2016)	31.2% age 10-17 (2020)	15.9% adults (2019)	6.5 new cases per 1,000 adults* (2018)
Healthy People 2030 Goals	12.8 per 100,000 people	27.7% adults	15.5 % age 2-19	5.0% adults	5.6 new cases per 1,000 adults

**data to align with Healthy People 2030 metric not available.*
Sources: *https://health.gov/healthypeople, https://nccd.cdc.gov/brfssprevalence/*
https://stateofchildhoodobesity.org/children2017/

Economy

Montana's median household income is consistently lower than its neighboring states and the national average as shown in Table 6, while Table 7 shows Montana's rate of poverty.

Table 6: Montana Median Household Income with Regional Comparison[16]

Median Household	Idaho	**Montana**	North Dakota	South Dakota	Wyoming	U.S.
2016	$51,807	**$50,027**	$60,656	$54,467	$59,882	$57,617
2017	$52,225	**$53,386**	$61,483	$56,521	$60,434	$60,336
2018	$55,583	**$55,328**	$63,837	$56,274	$61,584	$61,937
2019	$60,999	**$57,153**	$64,577	$59,533	$65,003	$65,712

Source: https://www.kff.org/statedata

Table 7: Poverty Rates 2016-2019[17]

State	**2016**	**2017**	**2018**	**2019**
U.S.	14.1%	13.4%	13.1%	12.3%
Idaho	14.4%	13.2%	12.0%	11.1%
Montana	**13.1%**	**12.6%**	**12.1%**	**13.1%**
North Dakota	11.6%	9.8%	10.2%	11.0%
South Dakota	13.8%	12.2%	13.3%	11.0%
Wyoming	11.7%	11.8%	11.1%	9.9%

Source: https://www.kff.org/statedata

Montana's traditional economy has consisted of extractive industries such as mining and timber; farming and ranching; and an increasingly dominant tourist industry. Government, education, and healthcare have also emerged as significant drivers of local economies. An interesting phenomenon created by COVID-19 is a large in-migration of tele-commuters from other states, such as Washington, Oregon, and California, which has driven housing prices up to near-unattainable levels for most Montanans employed in the industries noted above (with the possible exceptions of some education and healthcare sectors.) We may be about to face a radical shift in economic capacity of our cities' populations in particular; healthcare will need to observe carefully both what this means in terms of potential relocation of lower-income patients, payer mixes, and delivery of services.

Health Care Workforce Key Partners

HRSA, through a joint national effort between the Bureau of Health Workforce (BHW) and The Bureau of Primary Care (BPHC), has begun a national initiative regarding workforce focused on professional training within the primary care setting and all Montana FQHCs are enrolled in the process led by MPCA. The focus is to use a needs assessment that was already developed by a federal contractor to assess what is currently occurring on the ground in FQHCs, what is needed and then how to meet that gap. MPCA is leading that work for Montana. It is a three-to-six-year process. This work focuses on training programs for physicians and other licensed clinicians. The work overlaps with work being done by the

GME council (focused on creating, maintaining, and supporting physician residency programs in Montana), AHEC pipeline programs, and health support certification programs such as certifications or apprenticeships: Medical Assistance, Behavioral Health Tech, Care coordinators, peer support and community outreach workers.

In addition to the efforts of the Flex Performance Improvement Network and the QIO, across the state there are multiple quality improvement collaborations with active involvement from all types of healthcare organizations aiming to enhance safety and quality of health care in Montana. Some of these include clinically integrated networks, accountable care organizations, Rural Health Improvement Collaborations and Project ECHO activities.

The Health Care Economy in Montana

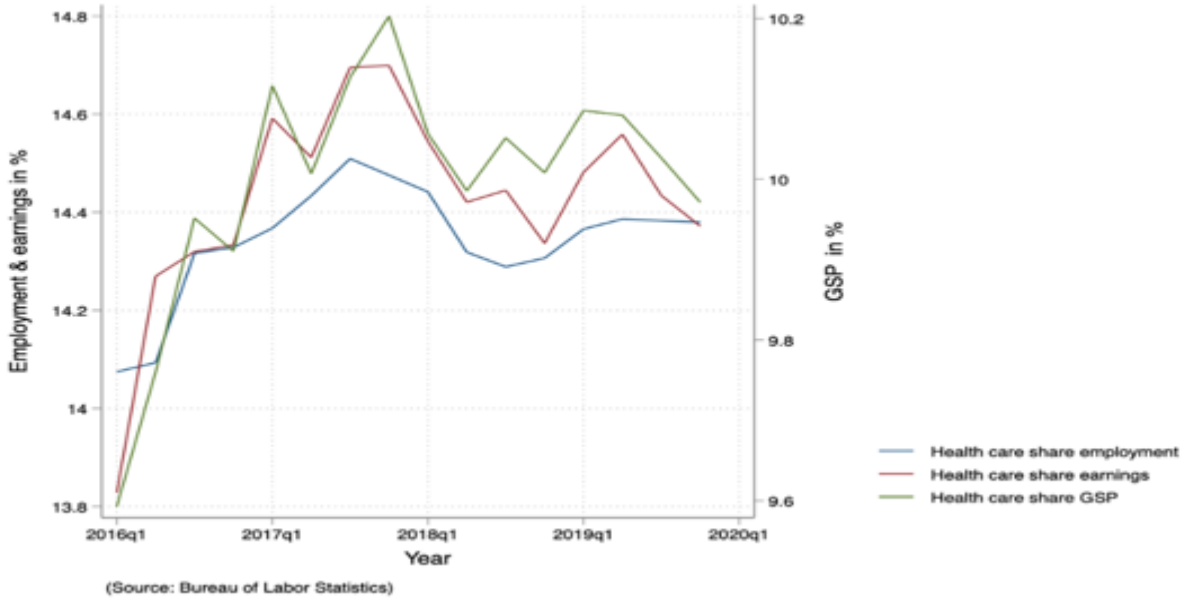
The impact of health care services on the Montana economy is significant, and is currently growing in relation to the overall economy. More than 100,000 Montanans work in health care, with about 85,000 of those individuals employed by hospitals.[18] As important to the economy overall, the impact in small, rural communities is even greater. Small hospitals provide important employment, salary and skills in addition to meeting the critical care needs of a community. Small hospitals are almost always the largest non-government employer in Montana's rural communities.

The University of Montana's Bureau of Business and Economic Research, in their April 2021 study of the economic impact of Montana's hospitals, stated that hospitals in particular, and health care in general, are labor intensive services that have a large locally produced component. Therefore, a comparatively large fraction of spending on hospitals is paid out as wages and thus remains in the economy.

Further, the study found that healthcare represents about 11.5% of the GDP in Montana today, and is expected to grow to more than 12% by 2030. It is reasonable that federal and state policies support sustaining health care services in rural communities. The loss of a hospital or clinic can devastate a local economy and leave its residents without reasonable access to health care services, including emergency medical transport and emergency room care.

Attracting or sustaining a vibrant business community requires local infrastructure. That infrastructure commonly includes up-to-date utilities, access to a skilled workforce, education and health care services.

Graph 1: Montana Health Care Employment and Earnings as a Percent of Total



Medicaid Expansion

Medicaid expansion has a substantial effect on Montana's economy. Expanded coverage is expected to ripple through Montana's economy, generating approximately 5,000 jobs and $270 million in personal income in each year between 2018 and 2020. In addition to generating economic activity, Medicaid expansion appears to improve outcomes for Montanans—reducing crime, improving health, and lowering debt. While the state pays 10% of each dollar of health benefits, the costs to the state budget are more than offset by the savings created by Medicaid expansion and by the revenues associated with increased economic activity.[19]

The Medicaid expansion project enrolled 92,700 Montanans as of December 20, 2020. To view the current enrollment and utilization data for expansion, view the Department of Public Health and Human Services website: https://dphhs.mt.gov/helpplan/medicaidexpansiondashboard. The beneficiaries consume about $870 million of health care services each year.[20]

Medicaid expansion is responsible for the considerable reduction in the uninsured rate from nearly 19% in 2015 to 10.3% in 2019 for non-elderly Montanans.

Table 8: Health Insurance Coverage of Nonelderly 0-64, States (2019)[21]

State	Idaho	**Montana**	North Dakota	South Dakota	Wyoming	U. S.
Employer	57.5%	**52.4%**	65.0%	61.0%	60.8%	58.1%
Individual	10.2%	**10.0%**	10.6%	9.9%	8.5%	6.9%
Medicaid	16.7%	**23.4%**	12.6%	13.8%	12.2%	21.0%
Other	3.2%	**4.0%**	3.2%	3.7%	3.6%	3.1%

State	Idaho	Montana	North Dakota	South Dakota	Wyoming	U. S.
Uninsured	12.4%	**10.3%**	8.6%	11.5%	14.8%	10.9%

Table 9: Who Provides Health Coverage for Montanans?[22]

Insurer	Number of People Insured
Employer Group Insurance	478,000
Medicare	201,000
Medicaid	193,231
Uninsured	76,000
Individual On ACA Exchange	52,358
Individual Off ACA Exchange	28,261
Prison	3,642

Source: Montana Insurance Commissioner, 2016

Tribal Health Improvement Program

The Tribal Health Improvement Program (T-HIP) is a historic partnership between the Tribal, State and Federal governments to address factors that contribute to health disparities in the American Indian population eligible for Medicaid and residing on a reservation.[23]

T-HIP services are designed to help members:

- maximize the benefits of their medical and other support systems; and
- improve knowledge of their disease and self-management skills; and
- remove the barriers to achieving better health and a better life.

Federally recognized tribes in Montana are the only eligible entities able to participate in and administer T-HIP. T-HIP is a three-tier program. A tribe may choose at which level they wish to participate. Implementation of Tier 1 is mandatory prior to participating in Tier 2 and Tier 3. Tier 1 focuses on high-risk, high-cost members identified by the Department of Public Health and Human Services.

Services provided under Tier 1 seek to improve the health of members who have chronic illnesses or are at risk of developing serious health conditions through intensive care coordination of individual members. The services in Tier 1 also seek to enhance the communication and coordination link between the member and the Passport primary care provider.

In addition to Tier 1 there are two other Tier choices. Tier 2 and Tier 3 address specific health focus areas that contribute to health disparities. Activities generally focus on improving the health of a population rather than individual members. (e.g. Obesity prevention program for grade school youth.)

Montana's Rural Health Care Challenges

Montanans living in rural communities face ever-increasing challenges to access reasonable health care services. The many challenges begin with the rural and frontier nature of the state. Long distances, isolated and small populations, and difficulty in recruiting medical professionals make it difficult to sustain health care services. Existing payment methodologies pose a challenge for relatively low volume hospitals, clinics and

EMS providers. Accessing specialty care oftentimes means traveling long distances.

While most rural and frontier communities are able to sustain a reasonable level of acute care through critical access hospitals, at least a few such facilities are contemplating a return to general hospital licensure status because their inpatient census occasionally includes more than 25 beds allowed under CAH designation.

An aging rural population will require more services of nearly all types, especially long-term care facility services, geriatric clinical care and other senior living options.

Montana has reduced its uninsured population, but its lower family income makes affording health care services more difficult.
Beginning in 2012, non-profit hospitals are required to conduct a community needs assessment of health care challenges and issues, along with developing a plan to meet these needs. They must conduct this community health needs assessment at least once every three years. The community needs assessments provide considerable insight into rural health care needs and challenges. The assessments commonly reveal an unmet need for behavioral health and substance abuse services, a threat to continued services by volunteer emergency medical services, and significant challenges related to the health status of the population. Obesity, heart disease, the growing prevalence of diabetes, and suicide are commonly cited.

Montana's hospitals provide exceptional care while simultaneously tackling the difficulties of their remote geographic location, small size, limited workforce, and constrained financial resources. The low patient volumes make it formidable for these facilities to manage the high fixed costs associated with operating a hospital. CAHs and rural hospitals typically offer a range of services needed in their communities despite their smaller patient and revenue base as well as high fixed expenses, making their cost per case higher.

CAHs are particularly vulnerable to policy and market changes, and to Medicare and Medicaid payment cuts. Long-range planning, financial forecasting and access to capital to invest in equipment or aged facilities are all challenging.

Montana's Rural Health Care Recommendations
This report clearly demonstrates the need for state and federal policy to reflect the rural and frontier nature of Montana. Federal policy mostly reflects a more urbanized view of health care delivery, while state policy oftentimes is required to follow the federal lead. State policymakers, including Medicaid and other regulatory bodies, should take steps to consider the impacts that payment and regulatory initiatives might have on rural and frontier communities. State advocates should ensure that the rural voice is heard and considered in national policymaking processes.

Section 2: Workforce

The development of an adequate and sustainable healthcare workforce continues to be a significant and ongoing challenge for Montana's healthcare community. The recruitment and retention of healthcare professionals and ancillary staff is especially challenging for the Critical Access Hospitals spread across the vast rural and frontier Montana landscape. This

section will discuss the current status of workforce development activities for each of the various healthcare disciplines.

Physician Workforce

Montana is served by two types of programs working to address the shortage of primary care physicians for rural and underserved areas – undergraduate and graduate medical education. The Montana WWAMI Program, a regional campus of the University of Washington Medical School, admits 30 Montana students, with 12 students in the Targeted Rural Underserved Track. These Montana students receive their education and training in rural sites throughout Montana.

Montana's residencies are successfully training Montana's physician workforce. Research shows that the most effective mechanism to improve access to health care for rural Montanans is to ensure that resident physicians train in rural communities. Nearly 63 percent of physicians graduating from Montana residencies are now practicing in Montana. This is the fourth highest rate of in-state practice in the country per Association of American Medical Colleges (AAMC) 2019 data.

Improving access to health care for rural Montanans: Over the last five years, the number of primary care residency programs in Montana has increased from one to four. These programs will be graduating 28 physicians per year in 2021 and 31 physicians per year by 2023.

Investing in Montana's future: Montana continues to have a significant shortage of primary care physicians and psychiatrists, especially in rural areas. This shortage makes it impossible for many Montanans to access health care in their communities and adversely impacts rural community economies. The shortage is related to:

- A historical lack of physician residency training (Graduate Medical Education) in the state
- An aging Montana physician workforce
- Fewer physicians entering primary care specialties and psychiatry

The Montana CAH Community Apgar Questionnaire (CAH CAQ) study, named for the Apgar score for newborns, was developed to quantify resources and capabilities that are indicative of current functioning in CAH communities' relative physician recruiting. The questionnaire study, originally developed in Idaho, utilized 50 factors important in recruitment and retention that were identified by literature reviews, site visits to CAHs and in discussions with physicians and administrators working at CAHs. The questionnaire study was delivered to 16 CAH organizations in the first year of the study in 2015. 7 additional CAHs were added to the study in the second year.

The results of the study showed the top three barriers/challenges in recruiting a primary care physician to a CAH in Montana:

1. Spousal Satisfaction (careers for spouses, able to integrate into the community)
2. Lack of Allied Mental Health Workforce (nobody to refer patients to)
3. Mental Health (the amount of mental healthcare providers had to deliver)

The CAH CAQ study also identified the top three areas of consideration factors for CAHs and their communities in physician recruitment:

1. Community Need /support of community
2. Employment Status (option to be employed by the CAH and/or independently, basically whatever status they wanted the administration to make work)
3. Income guarantee (comfortable with the fact that they didn't have to try to increase patient numbers and could focus on care)

The CAH CAQ study resulted in some innovative recruitment strategies, especially in the factors that CAH have no control over like climate (hospital arranged for the installation of a tank heater for new providers vehicles), and distance from shopping/amenities (providing Amazon Prime membership for providers).

The Montana Graduate Medical Education Council and the Montana Healthcare Workforce Advisory Committee have made the following recommendations related to the physician workforce:

- *Growing the number of Montana Residency Programs*: The cost of training a Resident is approximately $250,000 per year. Medicaid expansion has stabilized the fiscal viability of the Residency Programs in Montana by providing additional funding for residency programs. Medicare also funds a portion of this cost, along with teaching hospitals.
- *Support the Montana WWAMI Program and Targeted Rural and Underserved Track (TRUST)*: Provide extensive opportunities for medical students to experience rural and underserved settings throughout their education through the Rural Underserved Opportunities Program (RUOP) summer experiences, 3rd and 4th year clinical education in Montana longitudinal sites, Targeted Rural Underserved Track (MT WWAMI TRUST) experiences and education throughout medical school, and support for Montana physicians to serve as faculty.
- *Support Physicians in Rural Practice:* Programs that assist physicians to practice in rural areas include the Montana Rural Physician Incentive Program (MRPIP), a loan forgiveness program funded through surcharges on Montana WWAMI Medical Students. Other loan forgiveness programs are managed through the DPHHS Primary Care Office with the National Health Service Corps and State Loan Repayment Program.
- *New Programs, Teaching, and Clinical Capacity:* The Montana Healthcare Workforce Advisory Committee and the Montana Graduate Medical Education Council have supported a thoughtful, data driven approach to new program development that focuses on:
    - Recruitment and training of students who are from and likely to practice in Montana
    - Recruitment and training of Medical residents who are likely to practice in Montana
    - The best use of scarce teaching capacity by physicians in Montana hospitals, community health centers and community training sites

- The capacity for clinical education of both undergraduate (medical school) and graduate (residency) programs in Montana's hospitals, clinics and community sites.
- Providing affordable and cost-effective education that does not lead to unmanageable debt for future physicians

Physician Assistants

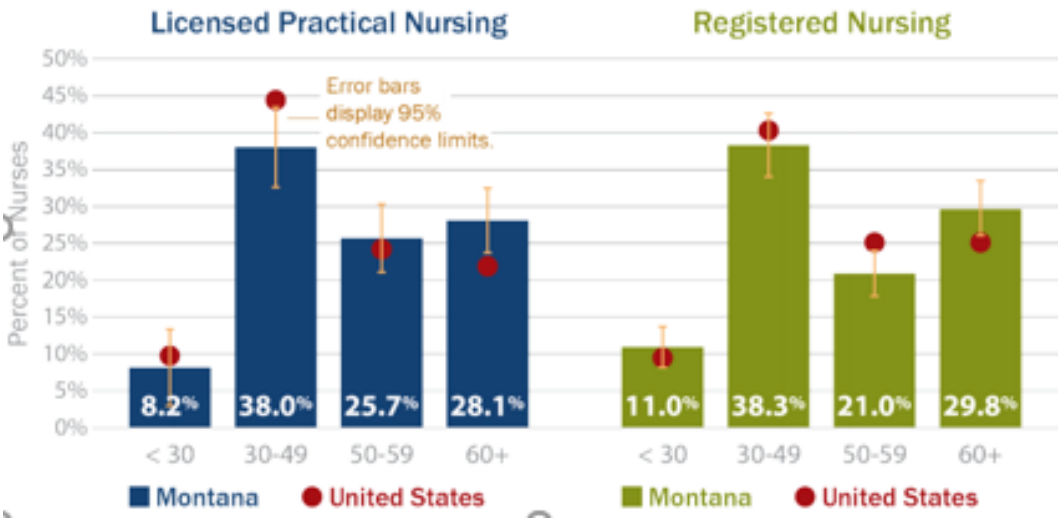
Physician Assistants play a crucial role in rural healthcare in Montana and are well-suited to improve access in rural locations. PAs often serve as the sole primary care provider in rural/frontier communities that have difficulty recruiting physicians. The Montana Physician Assistant workforce has shown significant growth in recent years with 20 annual openings per year (per DOLI). Recent licensure information, the American Academy of Physician Assistants (AAPA) 2015 National Survey, and a National Commission on Certification of Physician Assistants (NCCPA) study (2016) show the number of PAs practicing in Montana is over 500. The AAPA reports that about 38% of the practicing PAs in Montana were employed in a primary care capacity (family/general medicine, general internal medicine and general pediatrics) in 2013. The NCCAP reports 49.7 PAs per 100,000 population in Montana while the national figure is 34/100,000. Montana has the 8th highest concentration of PAs per 100,000 population in the country (from the NCCPA survey, 2016). We also know that eleven counties in Montana have no practicing PAs at all, while four counties have 59 or more, suggesting misdistribution of the PA workforce. Rocky Mountain College in Billings is the only training program for PAs in Montana.

Nursing Workforce

The Montana Department of Labor & Industry projects there will be an average of 445 additional registered nursing (RN) jobs in Montana every year through 2025.[24] Licensed practical nursing (LPN) is also estimated to experience large employment growth over the next ten years, adding 107 jobs per year through 2025.[25] Some of this growth in nursing occupations is due to an increase in the demand for nursing, as Montana's population continues to age and demand more services. However, over half of the projected employment needs in nursing are estimated to occur because of replacement needs.

In Montana, the average age of registered nurses is about 49 years old, which is roughly equal to the average age of RNs across the U.S. In general, the age distribution of RNs in Montana is similar to the nation. LPNs are slightly older in Montana than in the U.S. The median age of LPNs in Montana is 51 years old, compared to 48 nationally.

Graph 2: Age Distribution of Actively Licensed LPNs and RNs, Montana vs. U.S.



In *The Status of the Nursing Workforce in Montana*, summary results from the National Council of State Boards of Nursing (NCSBN) 2015 Survey, showed that, in the United States, 46.5% of RNs hold a bachelor's degree, compared to 36.7% with an associate degree. Montana is estimated to have more RNs entering nursing with a BSN than the national average, with over half (53%) of actively licensed RNs in Montana having entered their nursing career with a bachelor's in nursing (BSN). An estimated 75% of RNs under 30 years old hold a BSN as their initial nursing degree, compared to only 41% of RNs 50 and older. Just over 45% of Registered Nurses (RN) in Montana practice in a hospital setting. Another 14.2% practice in an ambulatory care setting, 7.1% in nursing homes/extended care, 3.7% in home health, 3.6% in insurance claims/benefits, 2.5% in academia, 2.5% in public health, and 2.3% in community health.[26]

Recent data from the National Center for Health Workforce indicate that 0.3% of RNs in the US identify themselves as American Indian/Native Alaskan. This contrasts with the nation's population of AI/AN, who make up 2 percent of the total population (US Census Data). On a state level, 6.6% of Montana's total population is Native American, and the percentage of Native American nurses in the workforce is estimated at 3.1%.[27]

Barriers to Clinical Training in Community-based Primary Care Teams

We know that experience in a rural/underserved setting will increase the number of students who will choose to practice in those communities. The biggest challenge to placing students in rural and underserved areas is the lack of preceptors. Recently completed workforce studies by the Rocky Mountain Tribal Leaders Council and the Montana Healthcare Workforce Advisory Council (MHWAC) found that health professional staff in underserved areas are often professionally isolated, have limited back-up to free up teaching time, and may lack advanced degrees (in nursing, PH, and allied health). Many Tribal and Indian Health services have a significant number of open positions, especially for physicians and dentists. Montana's Area Health Education Centers (AHECs) have been often been unable to place students in some underserved sites due to the lack of any physicians or dentists in the hospitals and clinics.

Another major barrier is the cost of sending students from the academic programs in Missoula, Bozeman, Billings and Great Falls to Indian Reservations and critical access hospital/rural health clinic communities that are 300 to 600 miles away. These rural placements have significant costs for travel; and housing is surprisingly expensive due to tourism in the summer, and there is an overall lack of housing year-round. Housing cost for a month-long stay can be well over $1,500 and roundtrip mileage costs from $300-$400.

Graph 3: Nursing Programs

MT UNIVERSITY SYSTEM AFFILIATION	COLLEGE	DEGREE	LICENSURE	LOCATION
Montana State University (MSU)	College of Nursing	BSN DNP	RN APRN	Bozeman
	City College at Montana State University	AAS ASN	LPN RN	Billings
	Great Falls College MSU	AAS ASN	LPN	Great Falls
	MSU Northern	ASN BSN	RN	Havre
University of Montana (UM)	Montana Tech of the University of Montana	ASN BSN	RN	Butte
	Helena College University of Montana	AAS ASN	LPN RN	Helena
	Missoula College University of Montana	AAS ASN	LPN RN	Missoula
No University Affiliation	Blackfeet Community College	AAS ASN	LPN RN	Browning
	Flathead Valley Community College	AAS ASN	LPN RN	Kalispell
	Miles Community College	ASN	RN	Miles City

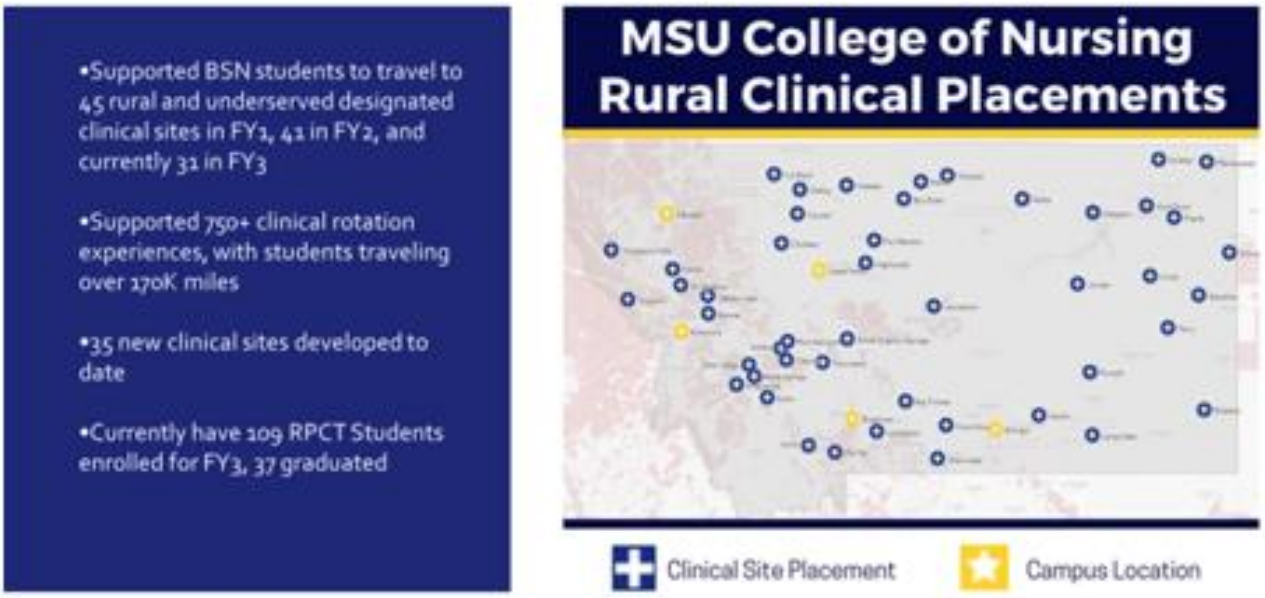
While the United States has faced a nursing shortage for several years, Montana not only continues to see a nursing shortage, but also a misdistribution of nurses throughout the state. The Montana Department of Labor predicts approximately 445 annual registered nurse (RN) and 107 licensed practical nurse (LPN) position openings every year through 2025. The demand for nurses remains high, especially in rural and frontier areas, due to Montana's aging population, an increasing number of people with diseases and co-morbidities, an expanding population, physician shortages, the implementation of health reforms, and changing delivery systems. The majority of Montana's nurses work in urban centers, leaving many job openings vacant in rural health care facilities. Moreover, Montana faces an aging nursing workforce, creating a greater shortage in the near future. The average age of the nursing workforce in the state is as follows: 49.8 (LPN), 48.4 (RN) and 50.2 (APRN).

Two recent grant-funded projects have provided an opportunity for Montana to implement and learn from an effort to place nursing students in rural primary care practice sites and

support the expansion of Doctor of Nursing Practice Nurse Practitioners in rural and underserved sites.

Nurse Education, Practice, Quality and Retention Grant
In 2018, the Montana State University and Montana Area Health Education Center built the Rural Primary Care Track, a unique training track for nursing students interested in primary care and serving rural, underserved Montana communities. Currently there are 109 Rural Primary Care Track students enrolled in the program and 37 have graduated. The track is designed to integrate community-based, primary care education into nursing didactics and allow students to travel to rural care settings from any MSU nursing campus. The participant benefits include rural clinical travel reimbursement funds; working intensively with seasoned nurse preceptors; and participating in a national inter-professional education certificate program, AHEC Scholars.

Graph 4: Rural Primary Care Track Clinical Site Placements 2018-2020



Since the inception of the program in 2018, Rural Primary Care Track students have traveled to over 45 rural and underserved designated clinical sites. Grant funds have supported over 750 clinical rotation experiences, with students traveling over 170,000 miles. There have been 35 new clinical sites developed as well.

With clinical travel reimbursement support, clinical coordination managed by designated rural clinical faculty at each of the five MSU nursing campuses, and the integration of additional educational opportunities through the AHEC Scholars program, the Rural Primary Care Track nursing students are better prepared to step into today's workforce and serve rural Montana upon graduation.

Advanced Nurse Education Workforce Grant
The Advanced Nurse Education Workforce (ANEW) Grant currently supports 22 graduate nursing students enrolled in Montana State University College of Nursing's Doctor in

Nursing Practice Program to be trained as Rural Ready Nurse Practitioners. Of the 22 Scholars, 15 are enrolled in the Family Nurse Practitioner track and 7 are enrolled in the Psychiatric/Mental Health Nurse Practitioner track. The ANEW Scholars participate in additional learning activities above and beyond the traditional DNP program requirements. Examples include additional elective course work, certification courses (rural emergency medicine; telemedicine; cognitive behavioral therapy), and participation in monthly seminars. Through the ANEW Rural Ready Nurse Practitioner Program, graduate students become academically and clinically prepared for the unique challenges of practicing and providing primary healthcare in rural and underserved communities.

ANEW Scholars must complete their clinical training in rural, underserved clinical sites in Montana. The grant provides funds to support the students' travel and lodging to their clinical locations. The grant also supports the students through tuition coverage and book stipends. The students' rural immersive clinical experiences allow them to increase their clinical knowledge by working closely with practitioners who are well suited to caring for rural communities; learn how rural communities function and rely on access to healthcare; and integrate themselves into team-based care settings to provide both family and mental healthcare to Montanans.

Recommendations for Nursing Workforce Development

The Montana Healthcare Workforce Advisory Committee and the Center for the Advancement of Health through Nursing made the following recommendations to address the shortage of nurses and advanced practice nurses working in rural and underserved communities

1. Increase employer support of and engagement in academic nursing initiatives in Montana in order to prepare a nursing workforce that will practice and improve health outcomes in rural and underserved sites
2. Promote graduate preparation options for Advance Practice Nursing, including Doctorate in Nursing Practice option with the IOM goal to double the number of nurses with doctorate degrees by 2020
3. Expand rural clinical education opportunities by developing more sites in rural and Tribal communities, and supporting student rotations with travel funds and stipends
4. Support programs of study that increase workforce diversity in Montana
5. Support the Caring for our Own Program (CO-OP) for American Indian students through MSU College of Nursing
6. Develop and support partnerships with Tribal College nursing programs
7. Increase the use of simulation in nursing education, and increase knowledge and skills related to
    a. Population Health
    b. Value based care and reimbursement
    c. Inter-professional teams
    d. Telehealth

Behavioral Health Workforce

Montana lacks both traditional behavioral health professionals in rural areas (psychiatrists, psychologists, psychiatric nurses, counselors and paraprofessionals.). It also lacks a basic infrastructure for delivering behavioral health services, with the majority of the state

having no dedicated behavioral health services in the county and community. Therefore, Montana relies on utilizing the primary care workforce and critical access hospitals to provide those services in the vast majority of rural Montana. Many organizations have struggled to serve the people who arrive in their emergency rooms, clinics, and community-based services presenting with MH, SA, and BH issues. Often the only option for people in crisis is a police transfer to a faraway service. Some are managed through telehealth, and most others through their primary care setting. Others are not addressed at all, often resulting in a shortened lifespan.

Behavioral Health Workforce Need: Most of Montana – except for Yellowstone County - is designated as a Health Professions Shortage Area for Mental Health Professions.[28]

The lack of mental health and behavioral health services is the top listed priority in community health needs assessments conducted by the Montana State Office of Rural Health with critical access hospitals. Access to behavioral health service in rural and frontier settings is impeded by limited availability of resources, stigma, economic issues, caregiver stress and isolation, and overlapping relationships in small communities. Additionally, lack of transportation, and the need to travel long distances to receive care limit access. Behavioral health workforce data from Montana Department of Labor and Industry (2015) identifies existing behavioral health workforce and number of counties without those practicing professions.

Table 10: Licensed Mental Health Workforce Data

Type of Provider	Total Number in Montana	Counties With None Practicing
Licensed Addiction Counselors	599	18
Licensed Clinical Professional Counselors	1074	13
Licensed Clinical Social Workers	708	15
Licensed Marriage and Family Therapists	124	33
Dual Licensed (LAC plus Mental Health)	194	31
Licensed Clinical Psychologists	214	31
Psychiatric Nurse Practitioners	58	40
Psychiatrists	88	40

Integrated Behavioral Health. Behavioral health is recognized as a critical component of overall health. The concept of integrated behavioral health, meaning behavioral health is incorporated into a care team in a primary care setting or primary care providers are incorporated into the care team in a behavioral healthcare setting, has taken a high priority as healthcare transformation efforts move forward across the nation and in Montana. The need for more integrated healthcare systems is evidenced by the health disparities experienced by individuals who suffer from behavioral health concerns, many of whom must currently navigate very complex systems of care at multiple service sites in their community in order to address their healthcare needs.

The Montana Healthcare Foundation cites a recent national survey that examined the

prevalence of behavioral health problems and corresponding access, or lack thereof, to treatment services in each U.S. state: Montana ranked 44th worst overall and 49th for youth. A serious shortage of treatment for Montanans struggling with behavioral health disorders complicates the problem. In 2016, only 25% of Montana's mental health professional needs were met, placing us in the bottom five of all states; 10 Montana counties had no state-approved substance use treatment program; and Montana's substance use treatment system met only roughly one third of the estimated need for medication-assisted therapy.

Findings from a recent study by the Montana Healthcare Foundation indicate that Montana providers who are currently implementing integrated systems often have the support of organizational leadership but could use technical assistance in a number of key areas, including implementing team-based care models, ensuring continuity of care and follow-up for patients, education and training for staff, and funding and resources specifically for IBH. Thus, even among clinics that have started moving toward integrating systems, this process is still in the early phase of development in Montana

A key problem for rural Montana is that Eastern Montana has one psychiatrist practicing in Glendive in an area of roughly 74,000 square miles. Integration in such an environment must be nearly entirely telehealth-dependent. This resource distribution issue is similar for all licensed mental health professionals.

Recommendations for Behavioral Health Workforce Development

- Support education and training programs that will address the critical shortage of behavioral health professionals in Montana:
  - University of Washington/Billings Clinic Psychiatric Residency
  - MSW Program beginning with 16 students at Carroll College in the Fall of 2021
  - Mental Health Nurse Practitioner, DNP (Doctor of Nursing Practice) at Montana State University
  - Support rural clinical placements for behavioral health professions students in clinical psychology, social work, counseling, and nurse practitioner programs
  - Provide paraprofessional training and continuing education that supports the expansion of Integrated Behavioral Health in rural hospitals, rural health clinics and community health centers
- Support rural hospitals, rural health centers, clinics and community health centers to expand Integrated Behavioral Health models that integrate primary care and behavioral health services.
- Provide training that will support the development of tele-psychiatry and delivering of behavioral health services via telehealth.

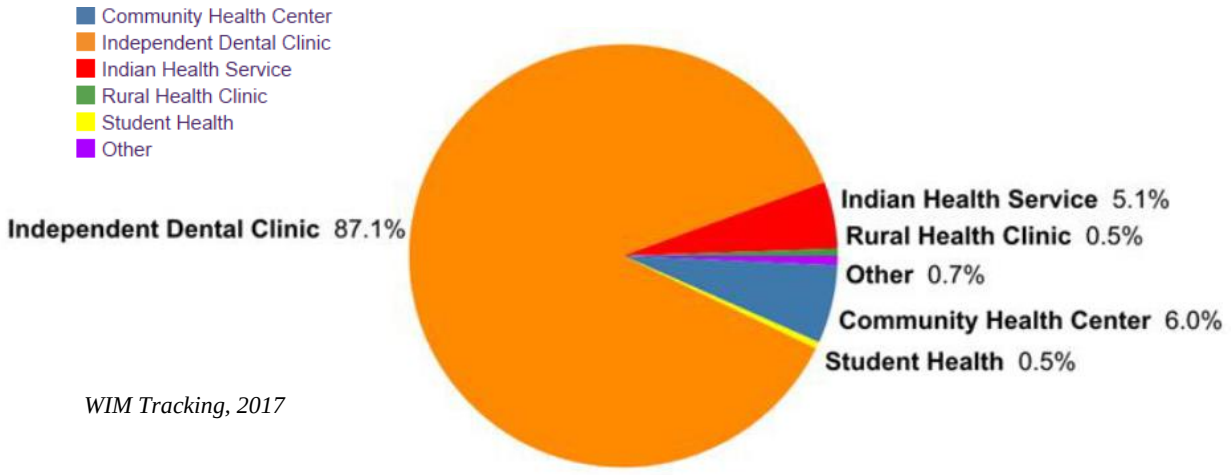
Dental/Oral Health Workforce

County Health Rankings provides a map with the ratio of population to dentists in Montana for 2017. Over 84% of Montana's dentists are general practitioners, specializing in family or pediatric primary dental care. Eleven counties in Montana do not have a full-time practicing dentist. These counties lie in the central and eastern regions.

The average drive-time for a resident in Eastern Montana (based on the county seat) to the nearest dentist is 48 minutes. For residents in Central Montana, the average drive-time to the nearest dentist is 40 minutes.

Dentists practicing in facilities available to the public include those in independent dental clinics, community health centers, and rural health clinics. Most general dentists (87.2%) in Montana operate through independent dental clinics.

Graph 5: Practice Settings of Montana's General Dentists, 2017



WIM Tracking, 2017

Many organizations have worked collaboratively with the University of Washington's School of Dentistry to bring dental students to Montana, both to provide needed dental services and as a recruitment and retention strategy in rural and underserved areas. This model has been supported in the Montana Oral Health Strategies Framework, in documents provided to and supported by the Montana Board of Regents, in the work plans of the Montana AHEC Program HRSA grants, and in the work of many volunteer dentists. Montana has continued to support rotations of UW dental students through its Oral Health Workforce Grant, the work of the Montana AHECs, contributions from MSU, and site support from CHCs and private dentists.

Recommendations for Dental/Oral Health Workforce Development

- Engage with and develop the capacity of underserved communities to support dental education and develop oral health services;
- Recruit and place dentists in rural, frontier, and Tribal communities providing increased access;
- Coordinate oral health workforce development and develop inter-professional models of oral health services and education across the state; and
- Continue work on the establishment of a WWAMI model regional campus of the University of Washington School of Dentistry at Montana State University, a concept that has been approved by the Montana Board of Regents.

Paraprofessional Workforce

At the request of the Montana Healthcare Foundation, the Montana Office of Rural Health/Area Health Education Center (MORH/AHEC) conducted an assessment of

paraprofessionals in the healthcare and behavioral health workforce in Montana. MORH/AHEC partnered with WIM Tracking, a health workforce research organization, to gather data on paraprofessionals in healthcare and behavioral health roles in Montana. Analysis included state licensure and credentials, employment data, surveys of employers, and contact with employers and educational programs.

Certified Nursing Assistants, Emergency Medical Technicians, Paramedics, Medical Assistants, Human Service Assistants, Psychiatric Technicians/Behavioral Health Technicians and Psychiatric Aides comprise the largest numbers of paraprofessional roles. Newly evolving roles of Peer Support Specialist, Community Health Worker, and Community Integrated Health – EMS/ Community Paramedic are growing across the state as training programs are developed and delivered.

Credentialed paraprofessionals are CNAs, Peer Support Specialists, EMTs, Advanced EMTs, Paramedics and Community Integrated Health Specialists. Paraprofessionals without a state license or certification are Community Health Workers, Medical Assistants, Psychiatric Technicians/Behavioral Health Technicians, Psychiatric Aides, and Human Service Assistants. Training, voluntary certifications, or national certifications are available through Montana University System campuses and Tribal Colleges, the Montana AHEC Program, and other online programs. Training programs are often developed in close consultation with the healthcare and behavioral health organizations that employ paraprofessionals.

Paraprofessionals can also obtain stackable credentials that increase skills levels and improve employment opportunities. Training such as Mental Health First Aid, Management of Aggressive Behaviors, and Motivational Interviewing, delivered in collaboration with community health centers and hospitals, can help develop the workforce needed for Integrated Behavioral Health.
There are paraprofessional roles that are unique to the Indian Health Service and Tribal Health. Community Heath Representative is a long-established role as frontline public health worker who provides health promotion, disease prevention, and outreach to indigenous community members. The Community Health Aides program was approved by the Legislature in 2019 and has 4 years to develop credentials. Behavioral Health Aides training programs are offered or in development in several Tribal Colleges.

Key findings from the study include:

- Paraprofessionals are working in every county in Montana.
- Paraprofessional training is provided in a variety of distributed training models including:
    - Courses offered in sites around the state (e.g. Peer Support, Emergency Medical Technician)
    - Courses offered through online courses (e.g. Community Health Worker and Certified Nursing Assistant)
    - On the job training (Medical Assistant, Psychiatric Aide)
    - Apprenticeships (Community Integrated Health, Community Health Worker)

- Professions that have recently become certified by the state (Peer Support, Community Integrated Health were the result of years of grassroots work by collaborative groups of volunteers, education, employers, and state agencies.
- Tribal Colleges offer training opportunities for behavioral health aides, and the Tribal Health Improvement Programs have been training paraprofessionals to work in care coordination roles. The newly authorized Community Health Aide Program is expected to provide an exciting new opportunity for paraprofessional services on reservations in Montana.

Recommendations for Paraprofessional Workforce Development

- Paraprofessional training opportunities must be available where people live and work. The distributive training models are an important method of meeting the needs of both learners and employers who may be distant from traditional educational programs
- The short length of training for many paraprofessional roles offers opportunities for career laddering by combining credentials (e.g., Peer Support and Community Health Worker); adding on certifications such as Management of Aggressive Behaviors; or structuring series of add-on trainings to build skills and employability. E.g.
    - CAN training in dementia and end of life
    - Community Health Worker training in chronic disease, transitions of care, population health
    - Behavioral Health Peer Support training to work with children and families
    - Medical Assistants to work as care coordinators
- The design and creation of paraprofessional training programs is best achieved through the collaboration of members of the workforce, employers, education, state associations, state agencies and community-based partners. Programs of the Montana Dept. of Labor and Industry should work with these collaborations to support targeted training programs.
- Most paraprofessional roles are not credentialed. It would be helpful to have more research into how credentials impact the utilization, funding, and job satisfaction of paraprofessionals.

Table 11: Paraprofessional Staff

Region	CNA	Peer Support	EMT & Paramedic	CIH-CP	Community Health Worker	Medical Assistant	Psychiatric Technician	Psychiatric Aide	Human Service Assistant
Montana Statewide	6,170	100	700	10	160	1,300	550	960	1,380
Billings MSA	1,160	10	--	2	40	290	160	--	270
Great Falls MSA	540	9	--	2	--	90	--	--	80

Region	CNA	Peer Support	EMT & Paramedic	CIH-CP	Community Health Worker	Medical Assistant	Psychiatric Technician	Psychiatric Aide	Human Service Assistant
Missoula MSA	770	14	50	--	--	170	--	--	110
East Region	770	7	40	4	--	50	--	--	70
Central Region	780	14	100	--	--	50	--	--	70
Southwest Region	1,070	35	200	--	--	330	--	850	520
West Region	940	11	280	2	50	330	--	--	260

Data sources: CNA, EMT, and paramedic data was taken from the 2017 Occupational Employment Statistics (OES) published by the Montana Department of Labor and Industry. Peer support data was provided by the Peer Support Network. CIH-CP data was provided by the Montana EMS & Trauma Systems. Provider data from the Peer Support Network and Montana EMSTS was assigned a region in alignment with the 2017 OES Regions based on the provider's county of practice.

Montana Area Health Education Centers and Healthcare Workforce Development

The Montana Area Health Education Center (AHEC) Program is funded by the Health Resources Services Administration of the U.S. Dept. of Health and Human Services. The AHECs have a unique role in building partnerships between education and the healthcare sector to address the shortage of healthcare professionals and paraprofessionals in rural and underserved areas. The AHEC Structure is:

Program Office: The Program Office is located at Montana State University, within the College of Nursing and in affiliation with the University of Washington School of Medicine. It is co-located with the Montana Office of Rural Health. The Program Office receives the federal funds for AHEC and coordinates activities among the five regional centers.

Regional Centers conduct activities to support the development of the healthcare workforce in collaboration with healthcare and educational partners. The Centers are:

- Western Montana AHEC: University of Montana
- North Central Montana AHEC: Montana Health Research and Education Foundation, MHA
- North Eastern Montana AHEC: Montana Health Network
- Eastern Montana AHEC: RiverStone Health
- South Central AHEC: Montana Health Research and Education Foundation, MHA

Key programs of the AHECs include the following:

- Pipeline programs including camps, school collaborations, HOSA, career preparation and education, and building experiences for students with local healthcare organizations
- Montana AHEC Interprofessional Education Scholars (IPE) Program: Students in health professions programs across Montana are engaged in a virtual two-year IPE training program that provides them with extensive knowledge and experiences that will support them in working in team-based care, healthcare transformation, integrated behavioral health, and population health.

- Training and continuing education: The AHECs offer a large number of training programs including:
    - X-Ray
    - CNA
    - EMS Basic and Advanced Certifications
    - Long term care skills and credentials
    - Behavioral Health
        - Community Health Worker
        - Fundamentals of Behavioral Health
        - Mental Health First Aid, Teen, Youth and Adult
        - ASIST suicide prevention
        - Secondary Trauma
        - Resiliency
        - Motivational Interviewing
        - Family and Children Certification
        - Financial Support for Peer Support Specialist and Community Integrated Health training
        - Others as needed
    - Continuing Education, e.g.
        - Nurse Residency
        - Friday Medical College

The AHECs play a major role in building partnerships at the state and regional level in collaboration with higher education, healthcare organizations, high schools, Tribal communities and community-based programs. These partnerships include:

- State and Regional AHEC Advisory Boards and Committees
- Montana Healthcare Workforce Advisory Committee
- Montana Behavioral Health Advisory Council
- Montana Graduate Medical Education Council
- State and Regional partnerships including Rural Community Opioid Response Program, Network Grants, Behavioral Health Education and Training Grants, Projects funded through the Montana Healthcare Foundation, and others

Healthcare Workforce Key Partners

Associations and Non-Profits

- Montana Hospital Association and Montana Health Research and Education Foundation
- Montana Primary Care Association
- Montana Medical Association
- Mountain Pacific Quality Health Foundation
- Montana Dental Association and Montana Dental Hygiene Association
- Montana Nurses Association
- Montana Behavioral Health Alliance
- Montana Healthcare Foundation

Local and Regional Organizations

- Critical Access Hospitals and Systems
- Regional Hospitals and Healthcare Systems
- Community Health Centers
- Community-based organizations
- Extension

State Agencies

- Montana Department of Health and Human Services
- Montana Department of Labor and Industry
- Office of Public Instruction
- Montana Department of Commerce

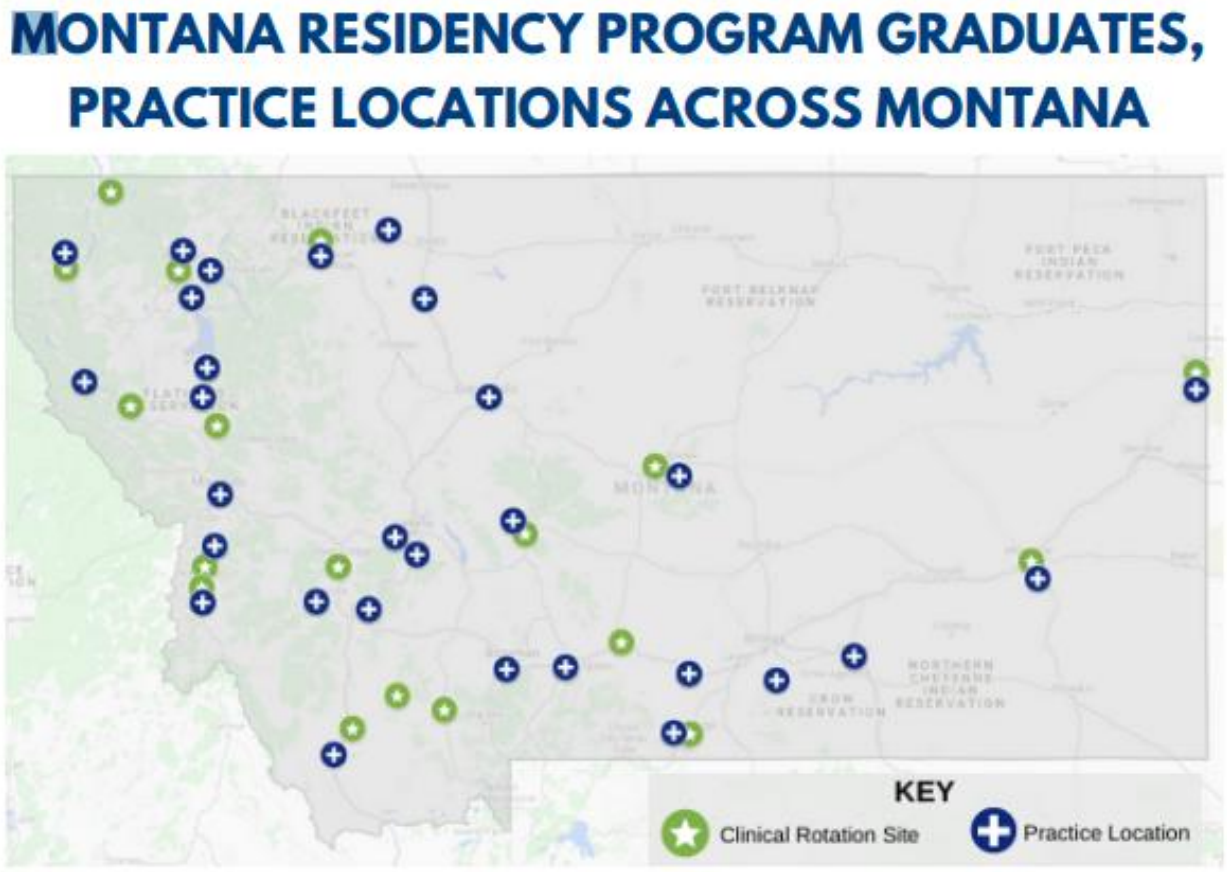
Educational Partners

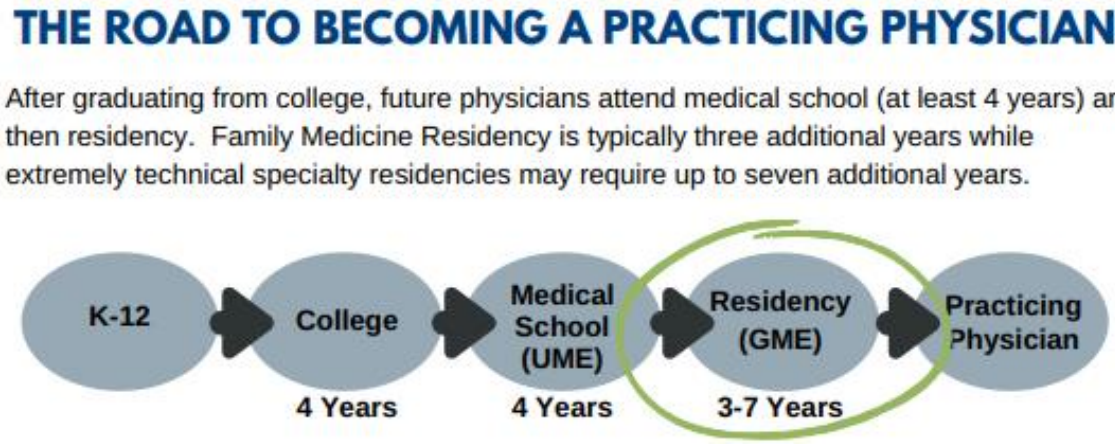
- Montana University System, Office of the Commissioner of Higher Education
  - Campuses of Montana State University
  - Campuses of University of Montana
  - Community Colleges
  - Tribal Colleges
  - University of Washington, School of Medicine and School of Dentistry
  - Private Colleges (Carroll College, Rocky Mountain College, University of Providence)
  - Simulation in Motion, Montana
  - Local schools

For more information:

Montana Primary Care Office, DPHHS - https://dphhs.mt.gov/ecfsd/primarycare
Montana Office of Rural Health/AHEC – http://healthinfo.montana.edu/workforce-development/index.html
Healthcare Workforce Strategic Plan, 2017:
http://healthinfo.montana.edu/workforce-development/mhwac/documents/MHW%20Strategic%20Plan%202017.pdf
Other reports in the process from various stakeholders include workforce reports for paraprofessionals, GME (Graduate Medical Education) and Physicians.

Graph 6: The Road to Becoming a Practicing Physician





Recommendations for Rural Healthcare Workforce Development

- Growing your own: Focus on young people and individuals who live and work in rural communities as the best source of the rural health workforce.

  K-12 – Support the Montana AHECs pipeline programs

  - Pipeline programs for K-12 students to interest them and prepare them for health professions
  - Link K-12 students to the healthcare organizations in their communities through classes, camps, mentors, and on the job experiences
  - Support health career pathway programs through OPI and OCHE that help high school students get healthcare credentials and college credit

  Adults and incumbent workers

  - Support the use of workforce development funds for healthcare training focused on people living and working in rural communities

  Equity

  - Provide educational and workplace opportunities for American Indian students and adults that incorporate language, concepts and context reflective of the culture, social and health needs of their communities
  - Partner with the Rocky Mountain Tribal Epidemiology Center, Tribal Health, Indian Health Services, Tribal Schools, Tribal Health and healthcare organizations that serve American Indian populations

- Provide clinical education for health professions students in rural and underserved communities, including opportunities for inter-professional experiences
  - Include longitudinal educational experiences that keep students connected to rural and American Indian communities throughout their training
  - Build partnerships with local hospitals, clinics, community and Tribal facilities that help them understand how to build capacity for clinical education
  - Support students through travel reimbursement and stipends as a method of encouraging rural clinical education
  - Utilize simulation as a method of building skills
  - Promote equity by working with RMTEC, Tribal Health, Indian Health Services and healthcare organizations that serve American Indian populations to identify, develop and establish clinical sites
- Develop opportunities for people working in healthcare organizations to move up career ladders through stackable credentials, apprenticeships, and clear pathways along career ladders
  - Build education and healthcare industry partnerships to understand the skills and credentials needed in rural healthcare settings
  - Create healthcare industry supported pathways that allow new and incumbent workers to build their skills and increase pay
  - Support healthcare professionals to advance in their careers by engaging in advanced training and credentials

- Support distributive models of education utilizing distance technology, distance education, and in person training in rural and Tribal communities
    - Online programs for all levels, from K-12 to practicing health professionals, that allow people to learn in the places they live
    - Build partnerships with larger healthcare systems for intensive clinical experiences for rural on-line learners, in skills that cannot be gained in small rural facilities
    - Establish partnerships with higher education and Montana Office of Public Instruction to encourage design of online, distributive education that meets the needs of the rural health system
    - Understand that online education may pose challenges for Tribal communities, and develop distributive models that serve those areas
- Seek out rural health professionals who have been trained and educated in Montana programs to serve as faculty, preceptors and mentors to the next generation of the healthcare workforce.
    - Connect with alumni of Montana health professions programs
    - Support their engagement in education and training through incentive programs, training and connection to higher education
    - Consider tax incentives for health professionals who serve as faculty
- Support a "Culture of Learning" in rural facilities that supports education and training as a core value and process
    - Provide technical assistance to healthcare leadership to support healthcare facilities in creating processes and procedures that support students and learning opportunities
    - Consider incentives, such as enhanced Medicaid reimbursement, for facilities that have achieved high standards for being a health professions teaching site

Section 3: Quality Improvement

The Montana Rural Hospital Flexibility Program and the Performance Improvement Network

The Medicare Rural Hospital Flexibility (Flex) Program was established by the Balanced Budget Act (BBA) of 1997. Any states with a rural hospital were able to establish a Flex Program and apply for federal funding that provides for the creation of rural health networks, promotes regionalization of rural health services and improves access to hospitals and other services for rural residents. Forty-nine of Montana's critical access hospitals benefit from the program and participate in the Performance Improvement Network (PIN). The mission of PIN is to develop and provide a collaborative support system which will enable small rural hospitals to have the ability to deliver quality care and achieve patient satisfaction and facilitate the sharing of resources related to meeting these goals.

For twenty-three years, the Montana Flex Program has been funded by the Federal Office of

Rural Health Policy (FORHP). Due to funding design, Montana Department of Health and Human Services is the official grantee, while entrusting over 80% of the work in a sub-recipient relationship to the Montana Health Research and Education Foundation (MHREF, the Foundation of the Montana Hospital Association.)

MT Flex uses funding to spur quality and performance improvement activities, stabilize rural hospital finance and integrate population health and emergency medical services (EMS) into existing health care systems. The program encourages the development of cooperative systems of care in rural areas to increase efficiencies.

The Montana Flex Program addresses four core areas, Population Health Improvement, Financial & Operational Improvement, EMS Systems and Integration, and Quality Patient Care. One could argue that work done in each area is Quality Improvement at the root cause level.

The Medicare Beneficiary Quality Improvement Program (MBQIP) is the data program that tracks and drives patient care improvement and activities for Montana CAHs. MBQIP metrics are in four focus areas of Patient Safety, Patient Engagement, Patient Satisfaction, and Care Transitions.

It is anticipated that, in an effort for rural relevant data and improvement, there will be future development of swing bed associated metrics, antibiotic stewardship improvement and support for rural health clinics.

Hospital Quality Improvement Contract (HQIC)

Montana Health Research and Education Foundation (MHREF) is the state contractor for the HQIC program that dates back to 2012 as the Hospital Engagement Network (HEN). The program went through several iterations, including the HEN 2.0, the Hospital Improvement Innovation Network (HIIN) contracts 1.0 and 2.0, and now HQIC. This ongoing initiative has been focused around different quality metrics related to patient safety in collaboration with the Center for Medicare and Medicaid Services' Partnership for Patients. The HQIC is a CMS funded quality initiative specifically focused on supporting rural hospitals, critical access hospitals, and those hospitals that serve vulnerable populations in achieving measurable outcomes under the rubrics of patient safety. HQIC also addresses the opioid epidemic and care transitions, in addition to the HEN/HIIN topics around hospital-occurring patient harms. Additionally, this project provides support to hospitals during public health emergencies, epidemics/pandemics and other crises as they arise. HQIC has three measurable goals to improve patient safety through quality improvement and technical assistance:

1. Improve Behavioral Health outcomes, with a focus on decreased Opioid Misuse
2. Increase Patient Safety with a focus on reduction of harm
3. Increase the quality of care transitions

The strategy for achieving these goals is to identify areas in need of improvement and to direct educational resources and technical assistance to assist facilities with that work.

Mountain-Pacific Quality Health QIN-QIO

Under the direction of the Centers for Medicare & Medicaid Services (CMS), Mountain-

Pacific Quality Health (MPQH) is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Hawaii, Alaska and the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands. Through the development and support of local coalitions, MPQH partners within these communities to coordinate healthcare system improvement with health care providers, practitioners, post-acute care settings, stakeholders, non-clinical entities, patients and their families.

Together with these local partners, MPQH works to:

- Improve the coordination of care from one health care setting to another and reduce the number of unnecessary hospital admissions and readmissions
- Support nursing homes' quality improvement and infection prevention programs
- Improve the wellbeing of, and care provided to, people with cardiovascular health issues
- Improve the wellbeing of, and care provided to, people with diabetes, pre-diabetes or at risk of getting diabetes
- Support community efforts to prevent and treat substance use disorders.
- Support providers with participation in quality data reporting and help them meet their quality program goals.

Quality Collaboration

Quality is a collaborative effort in Montana. Program tasks are specified by funders and can, unfortunately, often overlap. This leads to confusion and the possibility of duplicative work among programs. However, years of relationship building have allowed for collaborative efforts that equally benefit the healthcare system and staff, and quality programs.

A celebrated example of this is Montana's Antibiotic Stewardship (ABS) Collaborative. Antibiotic stewardship is a far-reaching topic, and the collaborative consists of the Montana Flex Program, HQIC, MPQH QIN-QIO, DPHHS Epidemiology, and the Skaggs School of Pharmacy at University of Montana. With regular gatherings and communications, Montana was able to effectively use resources and increase the strength of ABS programs in the state.

Collaboration has definitely impacted data scores, but our biggest wins are in the support and development of high performing Critical Access Hospital staff and providing the statewide network for these remote facilities to garner support and guidance from their peers, which in turn betters our entire state. Montana hospitals are increasingly recognizing and supporting the roles of Quality Improvement Coordinators and Montana has a strong network of hospital staff committed to quality improvement, and engaging in quality initiatives.

While the Antibiotic Stewardship (ABS) Collaborative is an example of a statewide network of collaboration among partners, collaboration between public health and health care is just as important in individual communities. Opportunities include working with local health departments on the community health needs assessments (CHNAs) and implementation plans (IPs) to identify shared priorities. Other entities in rural communities may also complete regular health assessments, including Federally Qualified

Health Centers, Human Resource Development Councils (HRDCs), and mental health-focused Local Advisory Councils (LACs).

Federally Qualified Health Centers are involved in a number of quality initiatives required by HRSA, specifically programs addressing people living with diabetes, Hypertension, cancer screening, particularly breast, cervical, and colon cancer, and depression and anxiety. MPCA partners with DPHHS on the cancer screening programs as well as a program with the UTAH Huntsman Center for cancer survivors and is a long- term active partner with the regional QIO, Mountain Pacific Quality Health. FQHCs report their data every year to HRSA and have been tracking these metrics for over 10 years. Specific metrics have been tracked in the fields of behavioral health and substance use disorder. Providers who needed additional education or who needed waivers to provide Medication Assisted Therapy have been tracked for the past 3 years. Montana moved from less than 5 waived providers to over 150 providers who were qualified to prescribe treatment for opioid use disorders. A concerted effort in monitoring and improving quality clinical work is a core function of MPCA with monthly reporting, reviewing, and training regarding quality with all its members.

Quality Challenges

The Patient Protection and Affordable Care Act of 2010 (ACA) includes a value-based purchasing (VBP) program which is designed to help advance quality and patient safety by tying Medicare hospital payments to performance on clinical process and outcome measures starting FY 2013. Critical Access Hospitals are excluded from this program due to low volume, as most may be unable to meet "Accountable Care Organization" requirements. Small numbers in rural hospital quality data can undermine statistical significance.

Rural quality programs suffer loss of momentum through turnover of CAH quality improvement staff which requires continuous training for new hires, often provided through networking and support of Montana quality programs. However, managing multiple requests for quality data from national, state and other sources adds to the workload of quality coordinators who are already stressed by fulfilling many different jobs within their organizations or wearing "multiple hats" as the saying goes.

Quality programs work best when leadership supports quality initiatives addressed as a team, with all staff involved understanding and supporting quality improvement. This support or environment is sometimes lacking and quality improvement and the intense data reporting that comes with it falls on the shoulders of one person.

Many national quality initiatives include measures that have little relevance to small, rural hospitals and it is difficult to find meaningful measures that tell the rural healthcare quality story. Many rural hospitals gather too much quality data and use too little key data for strategic purposes. The search for national rural-relevant metrics has been over a decade and still continues.

Recommendations for Health Care Quality

- Continue to provide peer networking and support to CAH quality improvement

personnel to minimize isolation and maximize shared expertise.

- Enable rural hospitals to be players in national quality initiatives and reporting.
- Support relevant data collection that can be used for making improvements or drive strategy.
- Continue to provide a platform for hospitals to learn from each other; profile hospital successes and best practices; use hospital staff in quality education workshops to help improve collaboration and learning outcomes.
- Effective Quality programs are supported from top leadership and providers and are not a department or a person, but imbedded in the work of all in a facility. Those on the front line doing the work are important quality champions and should be represented in quality initiatives.
- Support and expand the CAH Performance Improvement Network (PIN).
- Raise CAH data reporting and collection participation rates. Consider strategies to reduce health disparities between Native Americans and other Montanans by working with CAHs on or near reservations.
- Assist CAHs in meeting Medicare standards by developing specific action plans and templates to correct CAH survey deficiencies. Tie written action plans and templates to CAH survey deficiency tags and post on-line for efficient implementation of corrective actions by CAH staff.

Section 4: Accessing Acute Care in Rural Communities

Nearly all of Montana is classified as rural. But there is significant variability within that broad definition. Hospitals in Helena, Bozeman, Butte, Havre and Kalispell are classified as rural. Critical access hospitals in Livingston, Hamilton, Big Sandy, Scobey and Terry are likewise classified as rural. But the differences among those hospitals are considerable. The differences might best be characterized as related to population density and distance from tertiary population centers. While Montana's larger rural communities are served by hospitals, most of rural Montana is served by Critical Access Hospitals. And even among those communities with CAHs there is great disparity about the services offered, and the depth of the medical delivery system.

Montana currently has 49 CAHs, and there is one additional candidate hospital – Northern Montana Hospital located in Havre – which would likely benefit from conversion to CAH status. But Havre is located just inside the 35-mile radius from Big Sandy, making the conversion unlikely under current rules.

In rural communities currently served by CAHs, including Whitefish and Hamilton, the population is growing, and the facility is growing up to, and potentially beyond, the current 25-bed limit for CAH designation. In a stakeholder meeting for this plan, John Bishop, CEO at Marcus Daly Memorial Hospital in Hamilton, stated that the need for a slightly larger rural hospital reimbursement model is problematic since the existing fee-for-service payment models for hospitals significantly underpay small rural hospitals. CMS noted in the proposal of its outpatient fee schedules that rural hospitals would experience payment cuts of more than 10% under OPPS absent some protections. CMS offered a 3-year protection from payment reductions.[29]

In Montana communities considered to be frontier the CAH model may not offer long term stability or viability for high quality acute care. There are new models under consideration that provide for outpatient acute care, including access to emergency room services, but require that no inpatient care be offered.

Colstrip Medical Center (CMC) offers an example of the struggle to maintain needed services in a rural community without an acute care facility. CMC is a freestanding clinic that offers clinical services by 3 mid-level providers on a routine basis 5 days per week, between 8 am and 5 pm, plus urgent care on request after normal business hours and on weekends. Physical therapy, basic radiology, laboratory and telemedicine are among the services provided beyond clinic visits.

The facility is funded by a combination of fee schedule payments for professional services, subsidies from the local power plant and coal mines, plus a hospital district tax levy. The population of Colstrip is declining as coal mines reduce production or outright close operations, and the coal-fired power plants are being phased out.

CMC may require a new operating model to preserve reasonable care in its community. The clinic consistently operates in the red, and with the current economic trends will likely lose more money on operations. Service volumes are too low to benefit from Rural Health Clinic designation, while the options for a freestanding emergency department with a clinical service option is limited to existing critical access hospitals. Colstrip illustrates how health policy appears to focus on transitioning from hospital to critical access hospital to frontier acute care models, rather than to offer a 'best alternative' strategy to any rural community.

The Flex program could offer support for conversion among various models and continue quality and operational work post-conversion with a number of different healthcare models.

The current rural health care environment presents an opportunity to consider policy changes necessary to provide access to quality acute care and other medical services well into the future. Among those alternative payment models being considered and researched by CMS and other policy entities are:

- Consider alternative models for acute care
- Rethink the CAH designation criteria
- Rethink Outpatient Prospective Payment System (OPPS) for hospitals with fewer than 50 beds
- Rethink funding provider-based medical services under the CAH model

On December 27, 2020 Congress enacted H.R. 133, The Consolidated Appropriations Act, 2021 which included the following provisions related to rural hospitals and health care.

New Rural Emergency Hospital (REH) Designation

The legislation establishes a REH designation under the Medicare program that will allow existing facilities to meet a community's need for emergency and outpatient services without having to provide inpatient care. Emergency services would be provided 24 hours a day, 365 days a year, and communities would have the flexibility to align additional outpatient and post-acute services with community needs. REH's will receive a fixed monthly payment plus a 5% add-on to the Outpatient Prospective Payment System (PPS)

rate for outpatient services. The fixed monthly payment will be 1/12th of the average annual payment critical access hospitals received in excess of the PPS (for all services – inpatient, outpatient, skilled nursing facility) in 2019. The fixed amount will be adjusted each year by the hospital market-basket update.

Rural Community Hospital (RCH) Demonstration Program
This program allows hospitals with 25-50 beds to test the feasibility of cost-based Medicare reimbursement for inpatient services. The legislation extends the RCH program for five years. While the Act extended the existing demonstration program, the bill does not appear to expand the program to new participants. The RCH demonstration limits the number of hospitals that can participate to 30 total hospitals. Currently, 28 hospitals participate in the project. For more information, visit https://innovation.cms.gov/files/reports/rch-rtc.pdf. Congress has twice extended the RCH program to allow hospitals with 25-50 beds to test the feasibility of cost-based Medicare reimbursement for inpatient services. A 2018 evaluation of this program found that RCHs maintained access to quality care and largely benefitted from the demonstration reimbursement structure. AHA recommended that this program be made permanent and extended throughout the nation. As noted above, the project was extended for 5 years.

Frontier Community Health Integration Project (FCHIP)
The Frontier Community Health Integration Project Demonstration aims to develop and test new payment models for providing health care in the most sparsely populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures. Ten CAHs located in 3 states participated in the project. The model provided waivers expanding payments for three focused "prongs" for the "smallest of the small". FCHIP addressed 1. Telehealth, 2. Swing bed expansion, and 3. Waiving the 35- mile restriction for ambulance payments. Although the demonstration expired during 2020, the legislation extends for five years the FHIP demonstration project, which tests several care delivery innovations, including cost-based reimbursement for telehealth services. For more information, visit https://innovation.cms.gov/innovation-models/frontier-community-health-integration-project-demonstration.

The American Hospital Association, in its 2020 Rural Advocacy Agenda, endorsed several policies aimed at addressing access to acute care in rural communities. Among the initiatives endorsed by AHA:

Necessary Provider Designation for Critical Access Hospitals (CAHs)
The CAH designation allows small rural hospitals to receive cost-based Medicare reimbursement, which can help sustain services in the community. Hospitals must meet several criteria, including a mileage requirement, in order to be eligible.

A hospital can be exempt from the mileage requirement if the state certifies the hospital as a necessary provider; however, the necessary provider designation expired on Jan. 1, 2006. AHA seeks to re-open the necessary provider program, which would address the issues facing Northern Montana Hospital.

AHA also endorsed the concept of alternative acute care models for other rural and frontier

communities. These are some of the models under considerations.

Other Current State Initiatives

The Kansas Hospital Association is promoting "Primary Health Centers" to shift small rural hospitals away from a focus on admissions to more outpatient and transitional services. They are proposing two alternative models, both of which would be open 365 days a year, but one for 12 hours/day and the other 24 hours/day. Such a model will require changes in state licensing requirements to authorize this new provider type and changes in Medicare reimbursement policies.[30]

The Oregon Rural Health Reform Initiative is an effort to sustain rural hospitals financially by transitioning them away from a cost-based reimbursement model. Instead, rates at these rural hospitals will be negotiated with local coordinated care organizations, under the oversight of the Oregon Health Authority (OHA). Currently, OHA is working to determine which hospitals will remain financially viable should they shift to a coordinated care payment model, and which hospitals should continue to operate with cost-based reimbursement.[31]

National Initiatives

The Medicare Payment Advisory Commission (MedPAC) Proposal offers two possible models designed to preserve access to health services in rural areas while eliminating the financial burden of maintaining an acute inpatient care facility. In the first model, struggling hospitals would maintain their ED 24/7 and would also continue to provide outpatient services. Hospitals would be reimbursed by a PPS rate per service and would also receive a fixed grant to help offset standby costs. The second option involves hospitals transitioning to a primary care clinic or FQHC-like model that would be open between 8 and 12 hours per day, along with ambulance services that would be available at all times. These hospitals would also be reimbursed by a PPS rate per service and would receive a fixed grant to help fund the "ambulance standby capacity" as well as any other uncompensated care costs.[32]

The REACH Act (Rural Emergency Acute Care Hospital Act), (Mentioned early in this narrative as part of the December 27, 2020 Consolidated Appropriations Act 2021). The REACH Act was introduced by Senators Charles Grassley (R-IA) and Cory Gardner (R-CO), and would create a new Medicare payment designation called a Rural Emergency Hospital (REH), to sustain emergency care in rural communities. The new designation is aimed at addressing the difficulty that CAHs may have in achieving occupancy rates high enough to keep their inpatient beds, and thus the hospitals themselves, open. REHs would provide only 24/7 emergency care, observation care, and outpatient services (which could include telehealth services), as well as ambulance services to transport patients who need a higher level of care or inpatient admission to larger regional medical centers; REHs would not operate any acute-care inpatient beds themselves. CAHs and other small rural hospitals (<50 beds) that meet these criteria would be eligible for the designation. The idea is that these hospitals would likely be more financially viable without an inpatient center and could instead focus solely on stabilizing and transporting patients to larger regional medical centers, while continuing to receive the benefit of higher Medicare reimbursement rates.[33]

The Save Rural Hospitals Act introduced by Representative Same Graves (R-MO) would

reverse sequester cuts made to CAHs and small rural hospitals, and also seek to preserve or increase federal payments for low-volume and Medicare-dependent hospitals. Among other provisions, the Graves proposal delays penalties for small rural hospitals that have failed to transfer to an electronic health record system, and also increases Medicare payments for ground ambulance services in rural areas.[34]

Section 5: Integrated Delivery System

Providing access to health care in frontier and rural communities presents serious challenges. Among the various key issues facing critical access hospitals are preserving the most needed services in their service areas, developing a delivery system that provides access to acute services, clinic, long term care and emergency medical services. Maintaining a strong financial position and securing the needed medical and administrative expertise requires development of effective and lasting relationships within the service area as well as with distant tertiary providers. A key question for rural providers is whether to maintain an independent structure, develop affiliate and other network arrangements, or pursue acquisition by another health system.

Montana currently has 49 critical access hospitals and 19 federally qualified health centers. In combination with satellite clinics, there are 99 treatment locations throughout Montana, 57 rural health clinics and 70 skilled nursing facilities.

Mergers and Acquisitions, Affiliation, Networks

There are a number of CAHs that have entered into affiliated agreements with a tertiary health system or have been acquired by such a system.

Table 12: Health Systems[35]

System	Affiliated CAHs*	# Managed CAHs	# Owned CAHs	# Shared IT
Billings Clinic	2 Joint Ventures	8	2	12
Benefis Health System	0	1	1	0
Bozeman Health	4	0	1	1
Logan Health System	0	2	3	0
Providence	0	0	1	1
Sanford Health	2	1	0	1
Sisters of Charity	0	0	1	1

**Defined as some level of deeper affiliation beyond independence. Clinical collaboration (referral relationships), management contract employing CEOs, etc.*

Rural providers have long valued membership in provider associations and other network models to bring valuable skills, providing cost savings and sharing scarce medical resources among the memberships. Increasingly, a rural provider must decide whether to remain independent, or to seek arrangements that support financial and clinical stability, attract management and operational skills and meet the needs for closer relationships with tertiary medical centers.

Table 13: Networks[36]

Network	MT Health Network	Monida	MHA Ventures	MIHA
# Member CAHs	17	7	49	19
# Affiliated CAHs	20			

Services Offered	MT Health Network	Monida	MHA Ventures	MIHA
Rev Cycle	X	X	X	X
Education	X	X	X	X
Training Certification	X	X	X	
Insurance	X	X	X	
Recruiting	X		X	
Staffing	X	X	X	
Employee Benefits	X		X	
Peer Review	X	X		
Credentialing	X	X		
Group Purchasing	X	X	X	X

Telehealth

Montana was an "early adopter" of telehealth technology to bridge the distance barrier and provide access to medical care for rural populations. The Eastern Montana Telemedicine Network, originally designed as a hub-and spoke, interactive, audio-video telemedicine network centered at the Billings Clinic, began operation in 1992, one of the first telemedicine networks in the nation. Today, due to rapid innovations over the past 10 years, hard-wired telemedicine networks are becoming a thing of the past. As internet connectivity becomes faster, and hardware has become more affordable, telehealth is also taking place in patients' homes on their own devices. Now, healthcare providers of all types and credentials: medical, behavioral, speech/language therapists and others, are conducting telehealth from and to various locations, including FQHCs/RHCs, CAHs, as well as independent clinics and providers and patients' homes.

The change in being able to access healthcare providers quickly and easily has not kept pace with insurance companies' willingness to cover these types of visits in a way that is sustainable for both patients and providers. Emergency Room coverage has grown to include telehealth capability with Avera eED providing coverage to a number of very small CAHs in Eastern Montana. Additionally, a Federally-funded grant program, FCHIP, allowed 10 frontier CAHs in Montana, North Dakota and Nevada to test the efficacy of waivers for three "prongs" of payment relief affecting telehealth, swing beds, and ambulance service.

At the time of the publishing of this document, the reimbursement landscape has opened

up exponentially due to the COVID-19 payment waivers, allowing more people than ever before to receive telehealth services as a covered benefit- not just those that meet the requirements historically set by CMS. The changes made during the COVID-19 pandemic are being seen as a pivotal moment for telehealth, and for rural health advocates and policy makers. We see this as a critical opportunity to increase access to healthcare, specifically as it applies to rural Americans.

The publishing of the plan pre-dates many permanent changes that are being anticipated by the healthcare community as it relates to telehealth. The COVID-19 telehealth waivers have opened up telehealth as an option for care modality to more people in more ways than ever before. In the next five years, we hope that more rural residents have access to high-speed internet, that the medical services that they seek are reimbursed by their insurance carriers at the same rate when conducted via telehealth that they are when they are conducted in person, and that insurance carriers will expand the types of facilities and health care providers who can bill for telehealth services. It is the hope that these recommendations are considered when continuing to advocate for both state and national initiatives, policy changes, and infrastructure decisions.

Barriers and Challenges in Telehealth

Each of the recommendations above require the engagement of multiple stakeholders in order to advocate for sustained change.

Telecommunications companies are typically a private or some sort of private/public hybrid and are more likely to respond to investors and the market than they are to their customer base. The FCC and other federal agencies regularly provide funding to expand communications technologies to underserved areas. Mandates and/or federal funds may be options for achieving this goal, but it cannot be left up to telecommunications carriers to address this issue on their own.

Telehealth Stakeholders

Below is an incomplete list of stakeholder groups who may be helpful in achieving the goals that have been listed above.

- Montana Telehealth Alliance
- Montana Medicaid
- Montana Department of Public Health and Human Services
- Governor's office
- Indian Health Services
- Montana Hospital Association
- Montana Primary Care Association
- Big Sky Care Connect
- Montana Area Health Education Centers
- Telecommunications companies
- Community Paramedicine

Recommendations for Telehealth

- *Increase broadband access:* Much of Montana remains in a broadband desert. In many of these areas, internet connections that are not sufficient to maintain a live

video call are all too common. The old hub-and-spoke model of telehealth with adequate connectivity to a healthcare facility was the best way to connect a patient with their provider, which still may include a long drive. Ongoing efforts to eliminate broadband deserts for the sake of healthcare access should be included in telecommunications strategic initiatives.

- *Improve Billing & Coding Regulations for Telehealth:* As the healthcare community hopes that the relaxation of regulations and reimbursement policies in response to the COVID-19 pandemic will continue, there is also the need to improve and simplify the regulations regarding payment. Before the pandemic, the paltry $24 Facility Fee available to CAH organizations for providing telehealth consults was not worth the time it took to bill for the fee, so most CAHs didn't claim it. Additionally, if the telehealth payment waivers made available through the FCHIP pilot program were continued and applied to all frontier CAHs, telehealth services would expand exponentially.
- *Expanded access to civilian telehealth provider for Montana's Veterans:* Montana has one of the highest per capita populations of veterans in the country. The Montana VA system has a very robust telehealth network with services provided at 17 CBOCs (Community-Based Outpatient Centers), but most of them are in the urban communities and the larger rural towns. With one VA hospital in the state located in Helena, and 17 clinics, rural/frontier veterans still have challenges in accessing VA services due to travel and related costs. An integration between civilian telehealth providers and the VA network would go a long way toward improving access.
- *RHC and FQHC continued reimbursement for distant site services:* Telehealth has historically been utilized where RHCs and FQHCs acted as the spoke site to connect patients via telehealth to specialists. Only during the COVID-19 Public Health Emergency waivers were facilities first able to bill for distant site services for Medicare and private payers, and these payments became a vital revenue source to help facilities sustain business operations during the lockdown. Continuing to allow these facilities to provide distant site services to their rural residents would be a financial benefit to these facilities, and allow patients the convenience of telehealth with their primary care providers.
- *Ongoing expansion of available telehealth services from tertiary providers:* In spite of the significant expansion of the use of telehealth caused by the pandemic, adoption of telehealth delivered services, both primary and specialty, needs to accelerate beyond current levels. Physician satisfaction in using telehealth technology increased significantly during the COVID-19 pandemic, but telehealth is still not universally supported by providers. Improved relationships between rural/frontier providers and the tertiary providers are essential to making additional services available without travel for rural residents.
- *Primary care telehealth services:* As it relates to the above bullet point, RHCs, FQHCs, and independent clinics are vital resources to rural communities, and being able to provide, and be reimbursed for, direct-to- patient telehealth visits would enable these providers to offer their patients alternatives to in-person visits.
- *Behavioral health telehealth services:* Montana continues to lead the nation in suicide rates. Being able to reach rural patients via telehealth would provide practitioners

with a critical additional tool to provide these services to vulnerable populations. A recent joint venture between MHA Ventures and an independent psychiatry practice to provide emergent telehealth services to hospitals will improve access, especially for rural/frontier providers, but much more capacity is needed.

Integrated Behavioral Health

Rural communities struggle to find adequate access to behavioral health services of all types. There is a dearth of mental health care professionals throughout Montana, but the shortage is worse in rural and frontier communities. Many of Montana's rural counties are designated as health manpower shortage areas. (See Map 8)

The barriers to adequate access to behavioral health is reflected in Montana's poor performance and low national ranking for mental health, suicide, referrals to the Montana State Hospital. Rural and frontier communities face more difficult access to primary care providers, crisis intervention, inpatient hospital care and substance abuse treatment.

Community health needs assessments commonly identify unmet needs for mental health and substance abuse services. In turn, the communities, hospitals, and other providers have prioritized strategies to meet these needs. Integrating various screening and treatment options in primary care clinics, and expanding collaboration among mental health professionals in the community (where they exist) with hospital and primary care clinic practices are two areas of focus. Rural Montana communities have long relied upon telehealth services to enhance access to primary care visits and mental health counseling. Additional efforts are underway to expand these services to more treatment sites, and to make tele-psychiatry available to hospital emergency rooms.

The Montana Healthcare Foundation launched the Integrated Behavioral Health Initiative with the goal of transforming the standard of care for primary care providers in Montana. The Foundation has partnered with hospitals, clinics, mental health centers, the state health department and other stakeholders to improve health outcomes and reduce related costs through the widespread implementation of an integrated behavioral health model of care that emphasizes the effective use of existing resources and strengthening the alignment of community partners.[37]

The initiative partners have agreed that the core elements of integrated mental health care require a team-based approach to care, reliance upon evidence-based clinical treatment models, and improved care coordination across the treatment spectrum. The approach relies upon community leadership and a data-driven approach to system development of the continuum of care, including access to psychiatric consultation.

To date, the initiative has supported integration of behavioral health in 62 primary care settings, including 10 of the 11 larger hospitals in Montana, all 14 federally qualified health centers, 32 of the 49 critical access hospitals and 2 of the 7 tribal health departments and 4 of the 5 urban Indian health centers. The initiative provides technical assistance and training, while the state health department may provide grant funding to support the community efforts.

County governments and federally recognized tribal governments are eligible to apply for the County and Tribal Matching Grant. Counties and tribes can apply independently or

together as a region. The grants provide funding that requires an in-kind match rate based upon the ratio of their total population and their admissions to the Montana State Hospital. A single county or tribal government acts as the contracting entity.

A grant was provided to a block of 17 counties in eastern Montana in 2017. For 2021 the department has invited RFPs based upon four tiers. Tier 1 services are aimed at facilitating foundational pieces of a crisis system, such as a coordinator, a coalition, and resource mapping. Tiers 2 and 3 are for direct services for communities who have those pieces in place. Tier 4 is for technical assistance and start-up funding to plan for a regional crisis stabilization facility. Tier 4 requires active participation from the region's hospital(s).

EMS

HRSA put it well in its guide to community needs assessment of EMS: "The face of rural and frontier Emergency Medical Services (EMS) is changing. The number of potential volunteers in many areas is dwindling due to the ever-increasing age of the population. At the same time, expectations and requirements have increased, with all-hazards preparedness, pandemic disease and other preparedness requirements.

Many rural EMS agencies are fighting for their very existence. Others enjoy relative prosperity. Both want to do better."[38]

HRSA recommends that local EMS providers conduct a community-based needs assessment. This assessment should include:

- *EMS/Community Demographic Profile*. This profile will assist the facilitator in understanding the unique qualities of each EMS system and the community. It provides a snapshot of the EMS system organizational structure and the community's current status.
- *EMS Agency Self-Assessment.* This section provides an overview of the entire process and gives a quick internal snapshot of the EMS's employee/volunteer perception about how well the agency interacts with other community resources.
- *The Health Care System.* The goal of prehospital medicine is to stabilize, treat, and transport those who are critically ill or injured to definitive care. Definitive care may be a hospital, critical access hospital or rural health clinic.
- *The Public Safety System.* Managing an emergency scene often requires help from fire fighters and law enforcement. Fire fighters can assist in extrication or provide initial medical care. Law Enforcement officers secure the scene. Evaluate the EMS service interaction with public safety personnel.
- *The Political System.* Behind any EMS agency is the political system – those who govern the community. The political system governs many aspects of prehospital care regardless of whether EMS is a public, private, volunteer or hospital-based system. This section details the main concerns in making sure the political system and the EMS service are working together.
- *The School System*. Do educators and faculty interact seamlessly with EMS personnel during an emergency? Is the community prepared for tragedies like school shootings?
- *The Local/Regional Media*. Does the EMS service maintain a positive working relationship with the media? Do EMS and media representative have established

guidelines for handling news coverage during an emergency?
- *The Community at Large*. Does the EMS service provide the best possible care (protocol compliance, response time, clinical error rate)? Is the EMS service meeting customers' needs and expectations?

Emergency Medical Services in Montana: A Crisis on the Horizon

The Department of Public Health and Human Services, working with the Montana Hospital Association, conducted a status assessment by surveying EMS and rural hospital providers. The results, published as "Emergency Medical Services in Montana: A Crisis on the Horizon"[39] question whether a viable rural EMS system can thrive that relies on a volunteer work force, burdensome training, billing and technology needs, and chronic funding shortages emanating from low insurance payments, charitable contributions and local tax levies. The Executive Summary of the report is included here:

Executive Summary

Between February of 2019 and June of 2020, management staff from 42 hospitals and 61 EMS agencies were surveyed by trained interviewers to identify threats to Montana's EMS System and to identify recommendations for strengthening the EMS System. The survey and report were sponsored by the Department of Public Health and Human Services and the Montana Hospital Association and was partially funded by the Montana Healthcare Foundation. (Following the publication of the EMS Report and Survey, the Montana Healthcare Foundation and the EMS and Trauma Services Division have convened a work group to review the report and recommendations and begin work to address the impending crisis.)

Key Challenges

- Some EMS agencies are unable to respond to 9-1-1 calls because of staff shortages.
- EMS agencies are experiencing declining revenues.
- There is a lack of trained medical direction for EMS agencies.
- Hospital and EMS staff noted that there are challenges in navigating the two departments regulating EMS and EMTs.
- EMS lacks a unified voice to describe their needs and to request assistance.

Recommendations for EMS

- When practical, volunteer EMS agencies should seek to organizationally align with fire services, hospitals and clinics.
- DPHHS should create and share public information toolkits with EMS agencies.
- Create a pathway for the nurse practitioners to serve as medical directors.
- DPHHS should build on the Legislature's actions to create Community Paramedicine by seeking out reimbursement opportunities.
- Continuously evaluate the roles and functions of the state agencies overseeing EMS and EMTs to better support the needs of the EMS community.
- EMS stakeholders should support the development of an EMS advocacy organization.
- The state agencies overseeing EMS and EMTs should continue and expand education

opportunities through video conference, regional and local training.

Critical access hospitals must have adequate emergency transportation services to meet their local community's health needs. CAHs may, or may not, be in a position to step into EMS delivery systems to replace a volunteer EMS with a paid service, and to financially support the system without improved funding arrangements. Any movement of current CAHs to the proposed Rural Emergency Hospital (REH) will absolutely require a robust and sustainable EMS system.

FQHC Relationships and Integration

Two sister agencies within the US Department of Health and Human Services pursue strategies to provide access to primary care and other services in frontier and rural communities. The Health Research Services Administration (HRSA) has within its operational mission the development of federally qualified health clinics (FQHCs), commonly referred to as community health centers, while the Centers of Medicare and Medicaid Services (CMS) supports critical access hospitals and rural health clinics. The two agencies' strategies share a common goal of ensuring access by providing enhanced payments for CAHs, rural health clinics and federally qualified health centers. Together, the two clinic models have 156 treatment locations in Montana.

Montana has 15 FQHCs providing primary care to all people in Montana, especially to the most vulnerable populations. Twelve FQHCs operate as independent nonprofit health centers and two are county sponsored health centers. The Urban Indian Center in Helena operates as a look-alike FQHC. There are five Urban Indian Centers.

All 15 FQHCs provide primary care medical services with integrated behavioral health and substance use disorder services, pharmacy services, including 340B purchased medications and dental and oral health services. The clinics offer enabling, outreach and Medicaid enrollment services as well as a variety of integrated services depending on the needs of the community. For example, some provide WIC services on site, GED services, Title X family planning services, Accredited Child Evaluation Center, special health care for the homeless clinics and services and nursing home care.

All FQHC's have a sliding fee scale to ensure access to care. All FQHC's accept all insurances and must accept Medicare and Medicaid. Approximately 120,000 unique patients are provided care each year. In 2020 telehealth services increased astronomically from 1,000 telehealth visits to over 89,000. Telehealth services in every branch of health care including dental care will continue to play a significant role in rural health care delivery.

Rural Health Clinics operate in a very similar manner as FQHCs. RHCs are structured along the lines of more traditional small group physician practices, and the overwhelming majority of the RHCs are operated by community hospitals. RHCs offer a combination of medical and behavioral health services to the community, including 340B access to low-cost drugs. RHCs operated by a hospital follow the hospital's charity care policies for discounted or free care for low-income patients.

Every community is unique. RHCs and FQHC's conduct a community needs assessment at least every three years. Some of these assessments are jointly performed with community

partners such as the local hospitals and other health care partners. Some are conducted only by the hospital, others only by the FQHC.

Where one type of clinic or the other are located in a given community it appears that the sponsoring federal agency is accomplishing its goal. However, when the FQHC is located in a frontier community that has a critical access hospital and, or, a rural health clinic, problems can easily arise.

Among the common problems are competition for workforce and market share, duplication of primary care and ancillary services, maintaining relationships with tertiary providers and limited relationships with public health. Leadership of the competing entities may suffer from personality conflicts and a lack of trust or having a common Mission/Vision statement.[40]

The Montana Hospital Association and the Montana Primary Care Association have committed to working towards a more collaborative approach to providing care to ensure access to adequate services in frontier communities. This collaboration also intends to better coordinate care with local mental health center providers, substance abuse treatment and newly emerging for-profit MAT treatment centers.

Cindy Stergar, CEO, MPCA notes that her organization has a long-term strategy to begin community discussions in the MPCA work plan. Stergar noted MPCA has some funds to hire a consultant to help facilitate and organize some discussions.

There is renewed hope for creating sustainable health care models in rural and frontier areas with the acceptance and use of telehealth services, remote monitoring and maximizing all types of licensed and peer staff.

Integrated Technology – Electronic Health Record

Rural providers face considerable challenges and barriers to implementing a powerful EHR that can communicate with other community providers and distant locations. Among the barriers are access to affordable service platforms, securing skilled staff to manage EHRs, lack of adequate bandwidth from internet service providers and barriers to interoperability.

Despite the challenges, most critical access hospitals have adopted EHR technologies that rely upon small, stand-alone service providers, hosted EHR offered by tertiary hospitals or other smaller network EHR models.

Rural providers are now being asked to participate in a statewide health information exchange. Big Sky Care Connect is Montana's designated health information exchange (HIE), offering services necessary to enhance clinical care in communities throughout Montana. Big Sky Care Connect states that its services will improve health care quality, improve patient outcomes, and reduce medication and duplicated services. Sharing clinical information across treatment sites makes care more efficient by reducing unnecessary tests while providing a common clinical record of patient treatment needs.

Established in 2018, Big Sky Care Connect is overcoming implementation barriers created by the COVID-19 pandemic and hopes to enroll providers and begin sharing data during 2021.

APPENDIX A

Montana Rural Health Plan Task Force Members 2021

Carter Anderson
Inspector General, DPHHS OIG
Helena, MT

Anna Bradley
Public Health & Safety Division, DPHHS
Helena, MT

Natalie Claiborne
Montana Office of Rural Health
Bozeman, MT

Jennifer Doty, CEO
Sidney Health Center
Sidney, MT

Mary Erickson, DON
Pondera Medical Center
Conrad, MT

Shari Graham
EMS System Manager, DPHHS
Helena, MT

Chris Hopkins, CEO
Montana Health Network
Miles City, MT

Leslie Howe
Flex Program Manager, DPHHS OIG
Helena, MT

Devin Huntley, COO
Providence St. Joseph Medical Center
Polson, MT

Alyssa Johnson
Trauma Systems, DPHHS
Helena, MT

Kris Juliar, Executive Director
Montana Office of Rural Health
Bozeman, MT

Burt Keltner, CEO
Prairie Community Hospital
Terry, MT

Jack King, Director
Flex Program, MHREF
Helena, MT

Brenda Kneeland
EMTMHC, Behavioral Health Alliance of Montana
Billings, MT

Lindsay Konen
Flex Program, MHREF
Helena, MT

Lenette Kosovich
Chair, Behavioral Health Alliance of Montana
Billings, MT

Scott Malloy
Montana Health Care Foundation
Bozeman, MT

Patrick McConnell
Billings Clinic CAH Network
Billings, MT

Christen Obresley, Vice President
Northern Montana Hospital
Havre, MT

Heather O'Hara, RN, Vice President
Montana Hospital Association
Helena, MT

Bob Olsen
RWO Consulting, LLC
Helena, MT

Shani Rich, Executive Director
MHREF
Helena, MT

Amy Royer
Montana Office of Rural Health
Bozeman, MT

Julie Sakaguchi, VP
Monida Healthcare Network
Missoula, MT

Cindra Stahl
Montana Office of Rural Health
Bozeman, MT

Cindy Stergar, Executive Director
Montana Primary Care Association
Helena, MT

Jennifer Wagner, Rural Hospital Improvement Coordinator
Flex Program, MHREF
Helena, MT

Matt Waller
Population Health, Billings Clinic
Billings, MT

Ken Westman, CEO
Barrett Hospital & HealthCare
Dillon, MT

Mary Windecker, Executive Director
EMTMHC, Behavioral Health Alliance of Montana
Billings, MT

Roberta Yager, Director of Information Services
Montana Hospital Association
Helena, MT

APPENDIX B

Acronyms, Abbreviations and Definitions

3RNet	National Rural Recruitment and Retention Network
AAA	American Ambulance Association
AAFP	American Academy of Family Physicians
ACA	The Patient Protection and Affordable Care Act of 2010 or Affordable Care Act
ACHE	American College of Healthcare Executives
ACLS	Advanced Cardiac Life Support
ACO	Accountable Care Organization
ACS	American College of Surgeons
ADC	Average Daily Census
ADE	Adverse Drug Event
AED	Automated External Defibrillator
AFIB	Atrial Fibrillation
AFS	Ambulance Fee Schedule
AHA	American Hospital Association
AHC	Accountable Health Communities Model or Academic Health Center
AHEC	Area Health Education Center
AHIMA	American Health Information Management Association
AHQA	American Health Quality Association
AHRQ	Agency for Healthcare Research & Quality
AIM	ACO Investment Model
AIMS	Access Increases in Mental Health and Substance Abuse Services
AIR	All Inclusive Rate
ALOS	Average Length of Stay
ALS	Advanced Life Support
AMA	American Medical Association
AMC	Academic Medical Center
AMI	Acute Myocardial Infarction
AMIA	American Medical Informatics Association
ANA	American Nurses Association
APC	Ambulatory Payment Classification
APM	Alternative Payment Model or Advances Alternative Payment Model
AR	Accounts Receivable
ARRA	American Recovery and Reinvestment Act of 2009
ASC	Ambulatory Surgical Center
ATLS	Advanced Trauma Life Support
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
BCBS	Blue Cross Blue Shield
BCHS	Bureau of Community Health Services
BFCC	Beneficiary and Family Centered Care Quality Improvement Organization

BHP	Bureau of Health Professions
BHRD	Bureau of Health Resources Development
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement and Protection Act of 2000
BLS	Basic Life Support
BPHC	Bureau of Primary Health Care
BSC	Balanced Scorecard
BTLS	Basic Trauma Life Support
BRFSS	Behavioral Risk Factor Surveillance System data
CAC	Children's Asthma Care
CAH	Critical Access Hospital
CAHFIR	Critical Access Hospital Financial Indicator Report (FIR)
CAHMPAS	Critical Access Hospital Measurement and Performance Assessment System
CALS	Comprehensive Advanced Life Support
CAP	Community Access Program
CART	CMS Abstract and Reporting Tool
CAUTI	Catheter-Associated Urinary Tract Infection
CBO	Congressional Budget Office
CBSA	Core Based Statistical Area
CC	Care Coordination
CCHIT	Certification Commission for Healthcare Information Technology
CCM	Coordinated Care Model or Chronic Care Management
CCN	CMS Certification Number
CCO	Coordinated Care Organization
CDC	Centers for Disease Control
CDE	Clinical Data Exchange
CDI	Clostridium difficile Infection
CDS	Clinical Decision Support
CEHRT	Certified Electronic Health Record Technology
CEIC	State of Montana Department of Commerce/Census and Economic Information Center
CEO	Chief Executive Officer
CGME	Council on Graduate Medical Education CHC Community Health Center
CHIP	Children's Health Insurance Program
CHNA	Community Health Needs Assessment
CHSD	Community Health Services Development
CHW	Community Health Worker
CIT	Critical Illness & Trauma Foundation
CLABSI	Central Line-Associated Bloodstream Infection
CLIA	Clinical Laboratory Improvement Act of 1967
CME	Continuing Medical Education
CMHC	Community Mental Health Center
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant

CON	Certificate of Need
CoP	Conditions of Participation
COTA	Certified Occupational Therapy Assistant
COVID-19	Coronavirus Disease 2019
CP	Community Paramedic
CPC/CPC+	Comprehensive Primary Care Initiative
CPHQ	Certified Professional in Healthcare Quality
CPOE	Computerized Physician Order Entry
CR	Computed Radiography
DACA	Data Accuracy and Completeness Acknowledgement
DGME	Direct Graduate Medical Education
DHHA	Department of Health and Human Services
DME	Durable Medical Equipment
DON	Director of Nursing
DPHHS	Montana Department of Public Health & Human Services
DPU	Distinct Part Unit
DRG	Diagnosis Related Group
DSA	Disproportionate Share Adjustment
DUNS	Dun and Bradstreet Universal Numbering System
DVT	Deep Vein Thrombosis
EACH	Essential Access Community Hospital
ECG	Electrocardiogram
ECQM	Electronic Clinical Quality Measure
ED	Emergency Department
EDHI	Early Hearing Detection and Intervention
EDIE	Emergency Room Information Exchange
EDTC	Emergency Department Transfer Communication
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Labor Act
EMTN	Eastern Montana Telemedicine Network
FACHE	Fellow of the American College of Healthcare Executives
FCC	Federal Communications Commission
FCHIP	Frontier Community Health Integration Project
FEC	Freestanding Emergency Center
FEMA	Federal Emergency Management Association
FESC	Frontier Extended Stay Clink
FFR	Federal Financial Report
FFS	Fee for Service
FHSR	Foundation for Health Services Research
FI	Fiscal Intermediary
FIR	Financial Report Indicators
FLEX	Medicare Rural Hospital Flexibility Program

FMT	Flex Monitoring Team
FOA	Funding Opportunity Management
FORTH	Fiber Optic Rural Telehealth Network
FP	Family Practice or Family Practitioner (Physician)
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Center (FQHCs are community-based organizations that provide comprehensive primary care and preventive care, including health, oral, and mental health/ substance abuse services to persons of all ages, regardless of their ability to pay)
Frontier	Population area with 6 persons or less per square mile
HAC	Hospital Acquired Condition
HACRP	Hospital Acquired Conditions Reduction Program
HAI	Health Care-Associated Infection
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCPCS	Healthcare Common Procedure Coding System
HCRIS	Healthcare Cost Report Information System
HF	Heart Failure
HHS	U.S. Department of Health and Human Services
HIEM	Health Information Exchange of Montana
HIIN	Hospital Improvement Innovation Network
HIMSS	Healthcare Information and Management Systems Society
HIPPA	Health Information Portability and Accountability Act
HISPC	Health Information Security and Privacy Collaboration
HIT	Health Information Technology
HLQAT	Hospital Leadership Quality Assessment Tool
HPSA	Health Professional Shortage Area [HPSAs are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low-income population) or institutional (comprehensive health center, federally qualified health center or other public facility)]
HR	Human Resources
HRSA	U.S. Department of Health & Human Services/Health Resources and Services Administration
IBH	Integrated Behavioral Health
ICD-10	International Classification of Diseases 10th Edition
IHI	Institute of Healthcare Improvement
IHS	Indian Health Service
ILS	Intermediate Life Support
IOM	Institute of Medicine
IPAB	Independent Payment Advisory Board
IPPS	Inpatient Prospective Payment System
IQR	Inpatient Quality Reporting Program
IT	Information Technology
Lean	A set of tools, concepts and practices that help improve quality of care while reducing the cost and is accomplished by reducing errors, shortening cycle

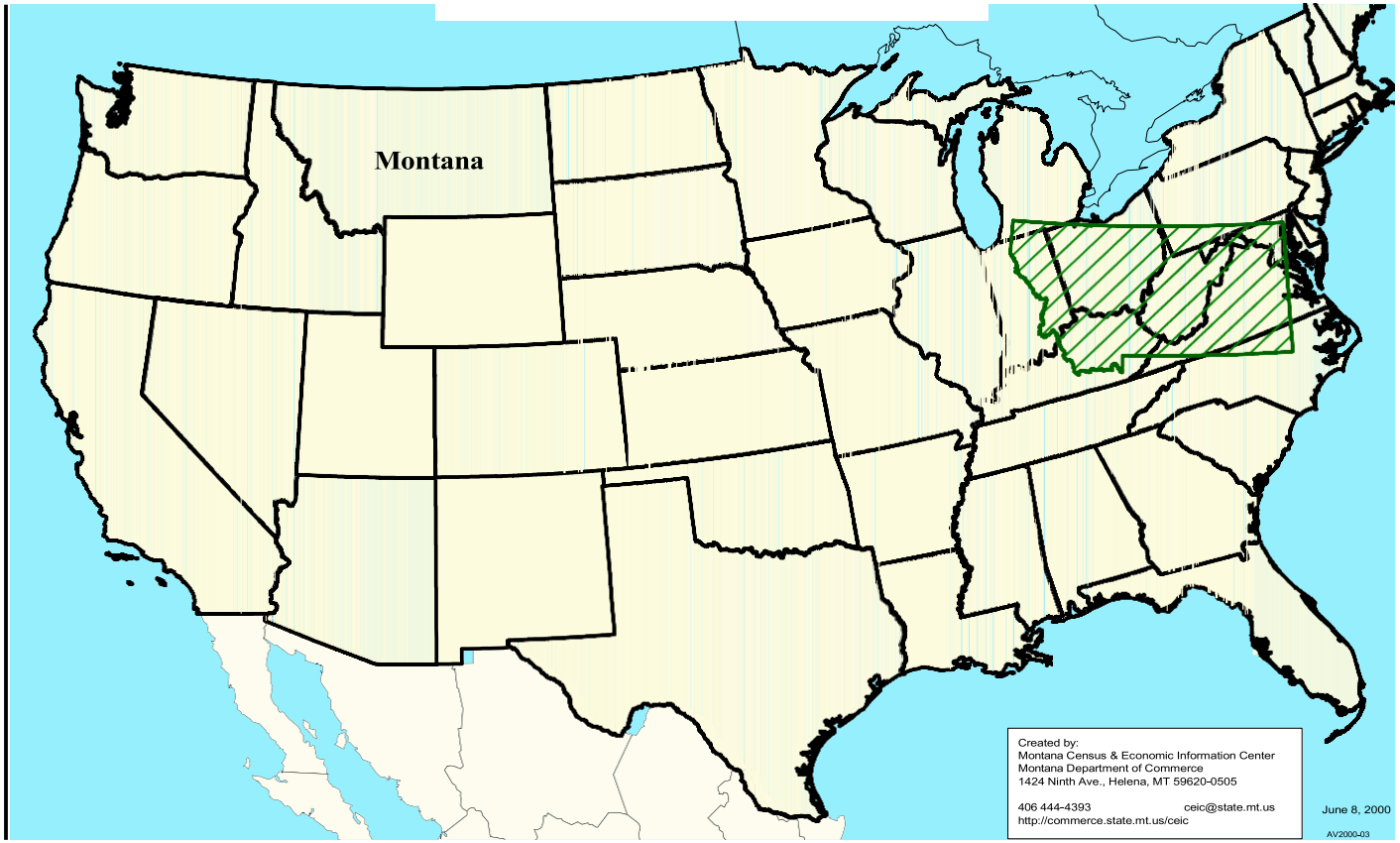
	times and eliminating waste.
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCREC	Joint Committee of Rural Emergency Care
LTC	Long Term Care
LTCF	Long Term Care Facility
MAF	Medical Assistance Facility
MBQIP	Medicare Beneficiary Quality Improvement Project
MHA	MHA...An Association of Montana Health Care Providers
MHCA	Montana Health Care Association
MHN	Montana Health Network
MHREF	Montana Health Research & Education Foundation
MHTA	Montana Healthcare Telecommunications Alliance
MORH	Montana Office of Rural Health
MPCA	Montana Primary Care Association
MPRH	Mountain-Pacific Quality Health
MRSA	Methicillin-resistant Staphylococcus aureus (bacteria that has developed resistance to many different antibiotics and troublesome in hospitals where patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public)
MUA	Medically Underserved Area (MUA/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population)
MVA	Motor Vehicle Accident
NACHC	National Association of Community Health Centers
NACRHHS	National Advisory Committee on Rural Health and Human Services
NAEMT	National Association of Emergency Medical Technicians
NARHC	National Association of Rural Health Clinics
NASEMSO	National Association of State Emergency Medical Services Officials
NHSN	National Healthcare Safety Network (a voluntary, secure, internet-based surveillance system that integrates and expands legacy patient and health care personnel safety surveillance systems)
NOSORH	National Organization of State Rural Health Offices
NRHA	National Rural Health Association
NTIA	National Telecommunications and Information Administration
NMHA	Northcentral Montana Healthcare Alliance
OIG	Office of Inspector General
ORHP	Office of Rural Health Policy
PACS	Picture Archiving Communication System
PCO	Primary Care Office
PDSA	Plan Do Study Act (A system for testing change in the work setting by planning, doing, studying and acting on what is learned. This is the scientific method used for action-oriented learning.)
PIN	Performance Improvement Network
POA	Present on Admission
PPS	Prospective Payment System

PT	Physical Therapist
PTA	Physical Therapy Assistant
QHI	Quality Health Indicators
QHP	Quality Health Plan
QNet	Quality Net
QIO	Quality Improvement Organization (QIO's program is to improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries)
REACH	Realizing Education and Community Health Telehealth Network
REC	Regional Extension Center (REC is an organization that has received funding under the Health Information Technology for Economic and Clinical Health Act (HITECH Act) to assist health care providers with the selection and implementation of electronic health record technology)
RHC	Rural Health Clinic (RHC is a clinic which is located in a rural area designated as a shortage area, i.e., an area experiencing a shortage of either personal health services or primary care manpower)
RHIO	Regional Health Information Organization
RHPI	Rural Hospital Performance Improvement Project
ROSC	Rural Organization Safety Culture
RPCA	Rural Primary Care Hospital
RTAC	Rural Trauma Advisory Councils (regional) (RTAC with facility representatives from each of the three Montana Trauma Regions meeting quarterly to identify specific regional trauma care needs and to define corresponding strategies, propose trauma care guidelines to the State Trauma Care Committee and to develop Regional Trauma Care plans)
RTTD	Rural Trauma Team Development
SAMHSA	Substance Abuse and Mental Health Services Administration
SBAR	Situation Background Assessment Recommendation (a technique used to improve communication between members of a health care team)
SCIP	Surgical Care Improvement Project
SDOH	Social Determinants of Health
SRHP	State Rural Health Plan
STAC	State Trauma Advisory Council Tertiary Medical Center A major hospital with a full complement of medical services including specialty & sub-specialty physicians plus diagnostic & treatment capabilities
WCC	Wound Care Certification
WWAMI	Washington-Wyoming-Alaska-Montana-Idaho (medical school for 5 states) (The cooperative medical education program for Washington, Wyoming, Alaska, Montana and Idaho, designed to make medical education accessible to students in the mostly rural Pacific Northwest by sharing existing facilities and personnel in universities and communities in the WWAMI states)

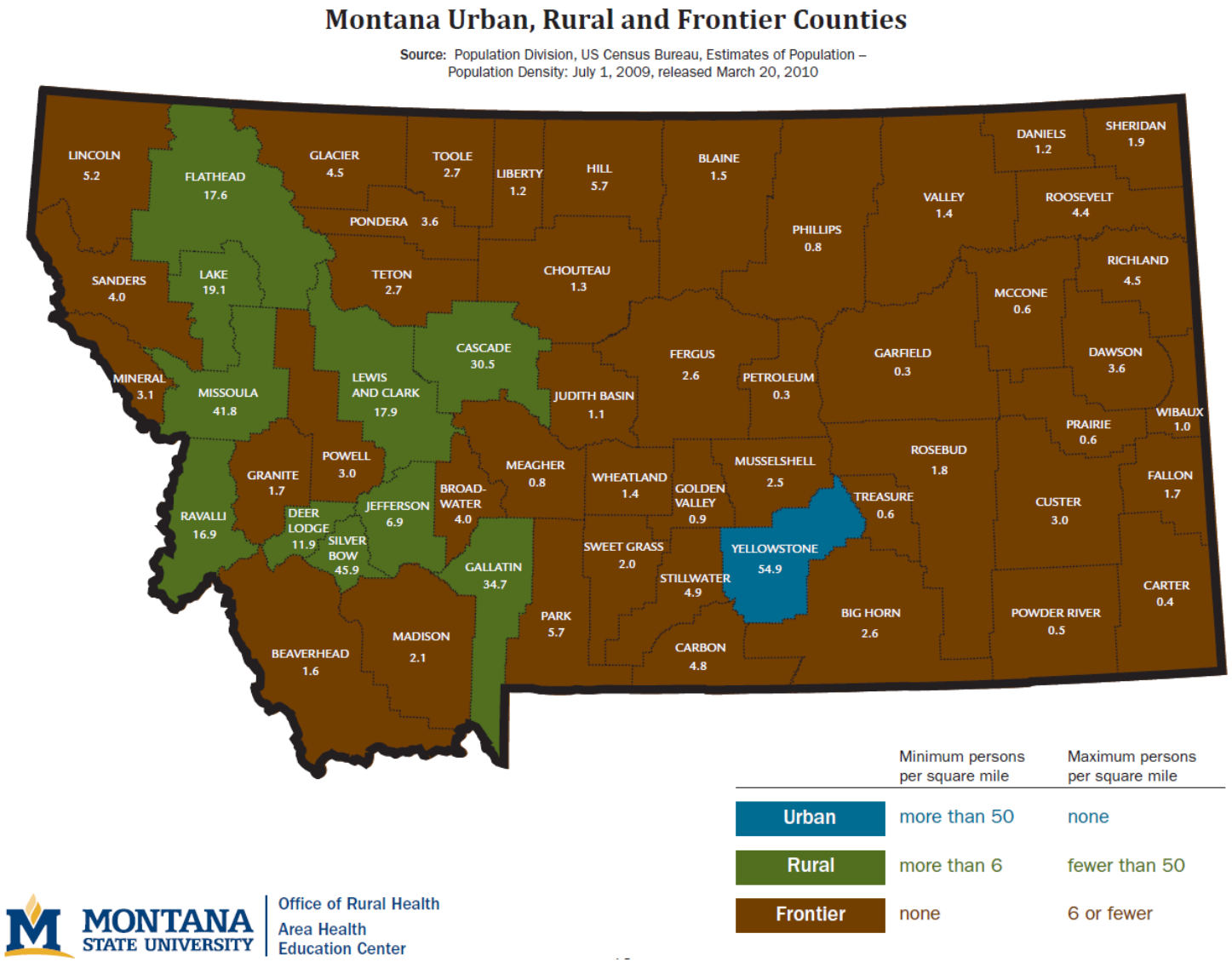
APPENDIX C

Maps and Graphs

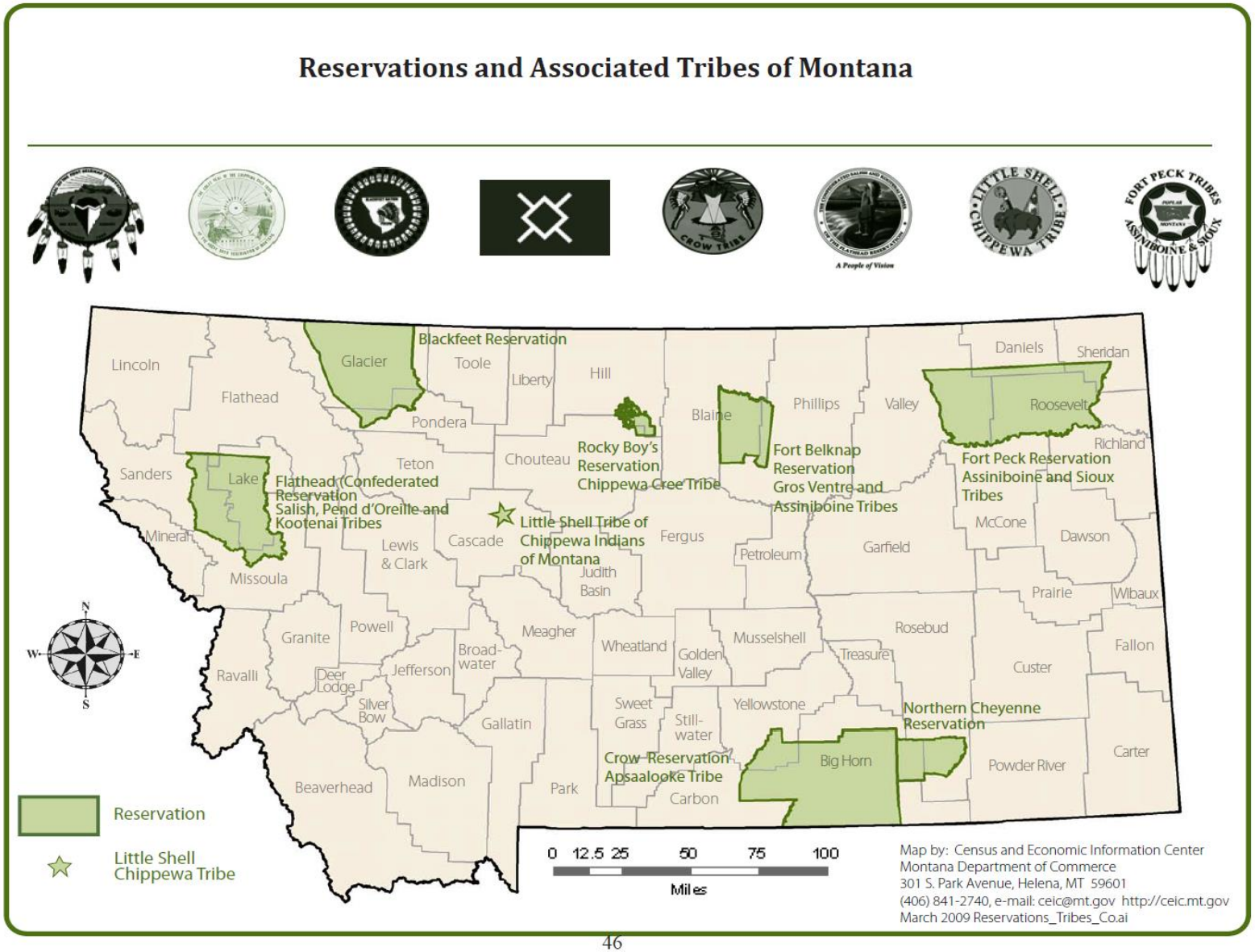
Map 1: Montana Overlaid on a U.S. Map



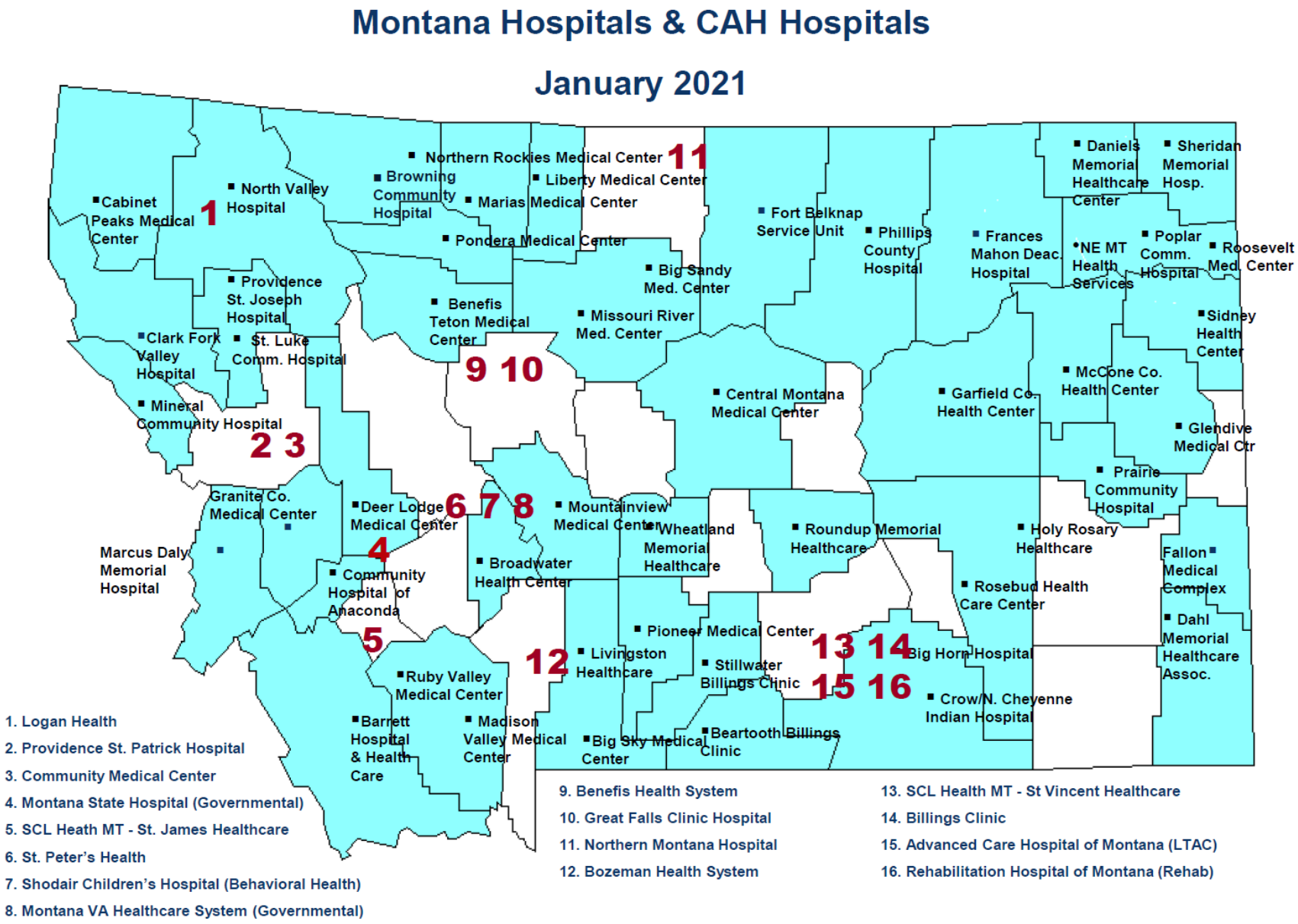
Map 2: Montana Urban, Rural and Frontier Counties



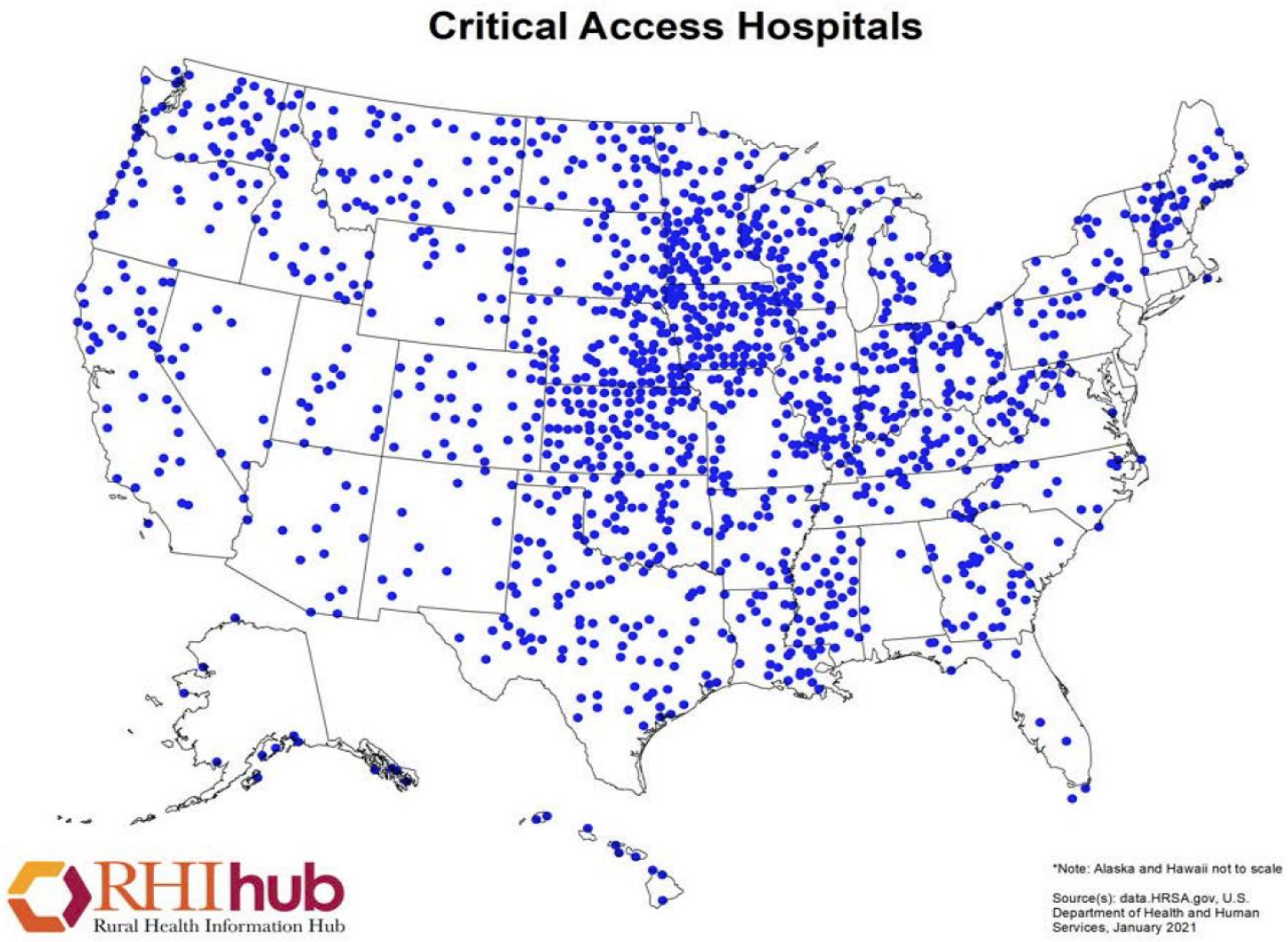
Map 3: Reservations and Associated Tribes of Montana



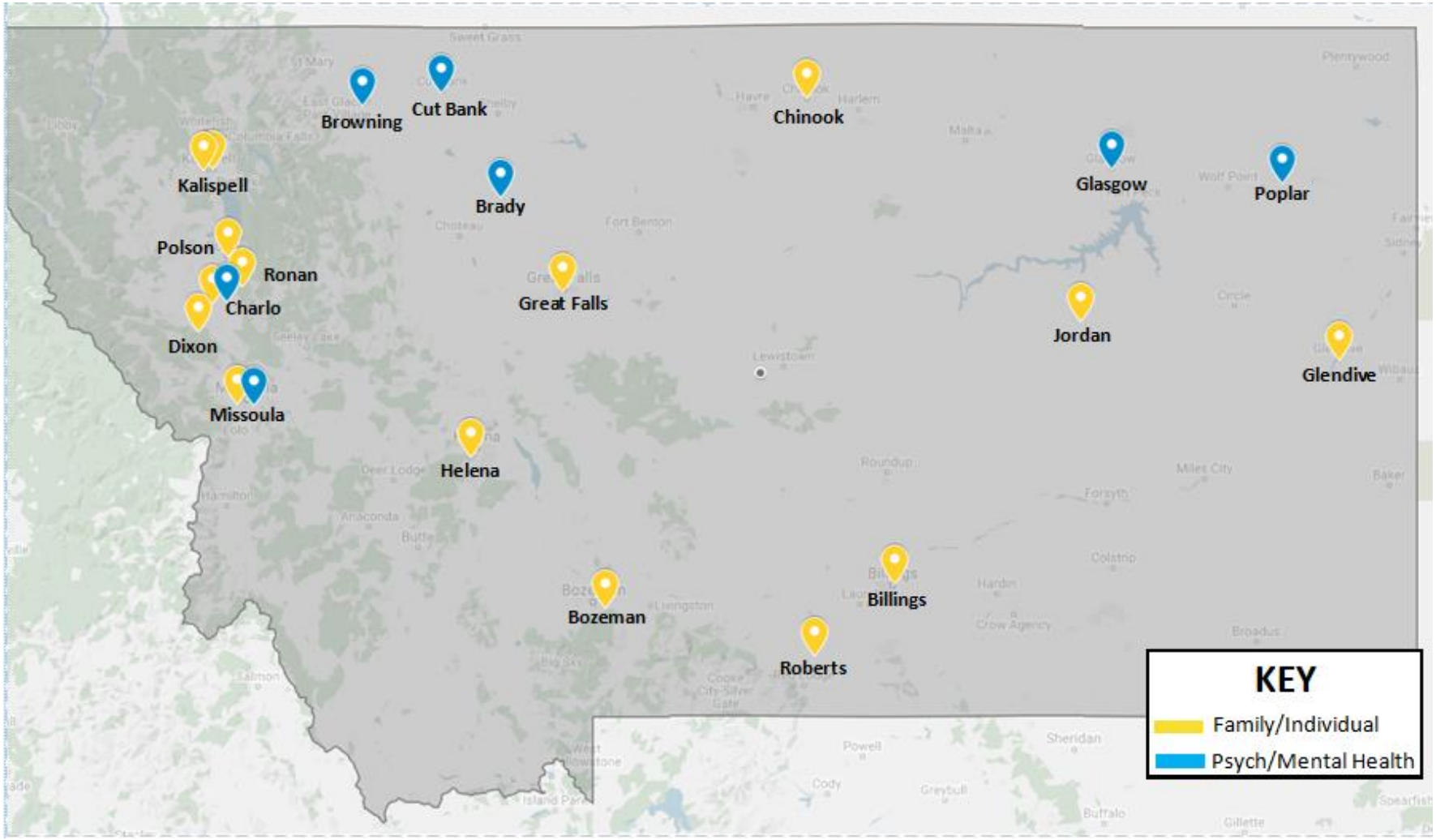
Map 4: Montana Hospitals and Critical Access Hospitals, January 2021



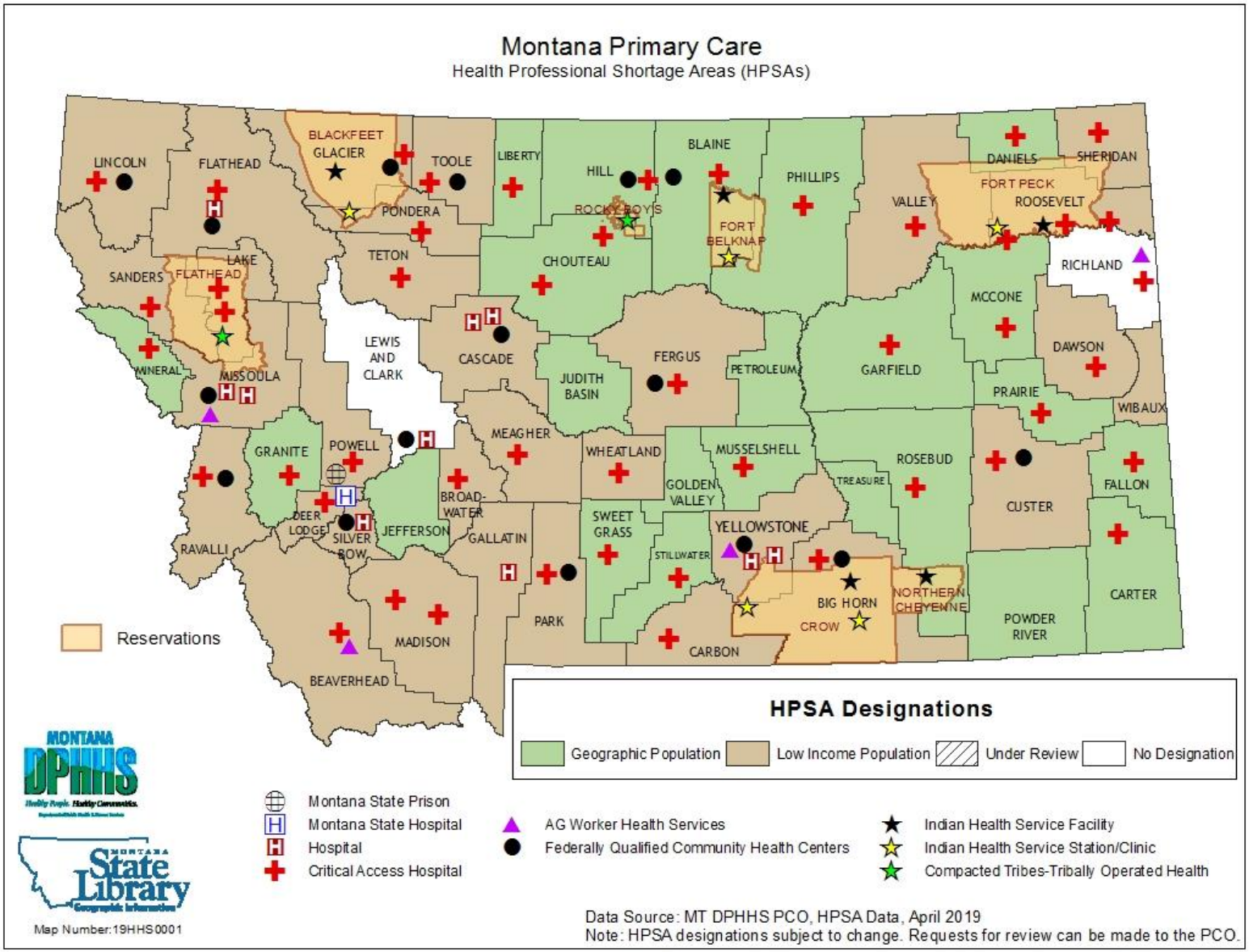
Map 5: U.S. Critical Access Hospitals



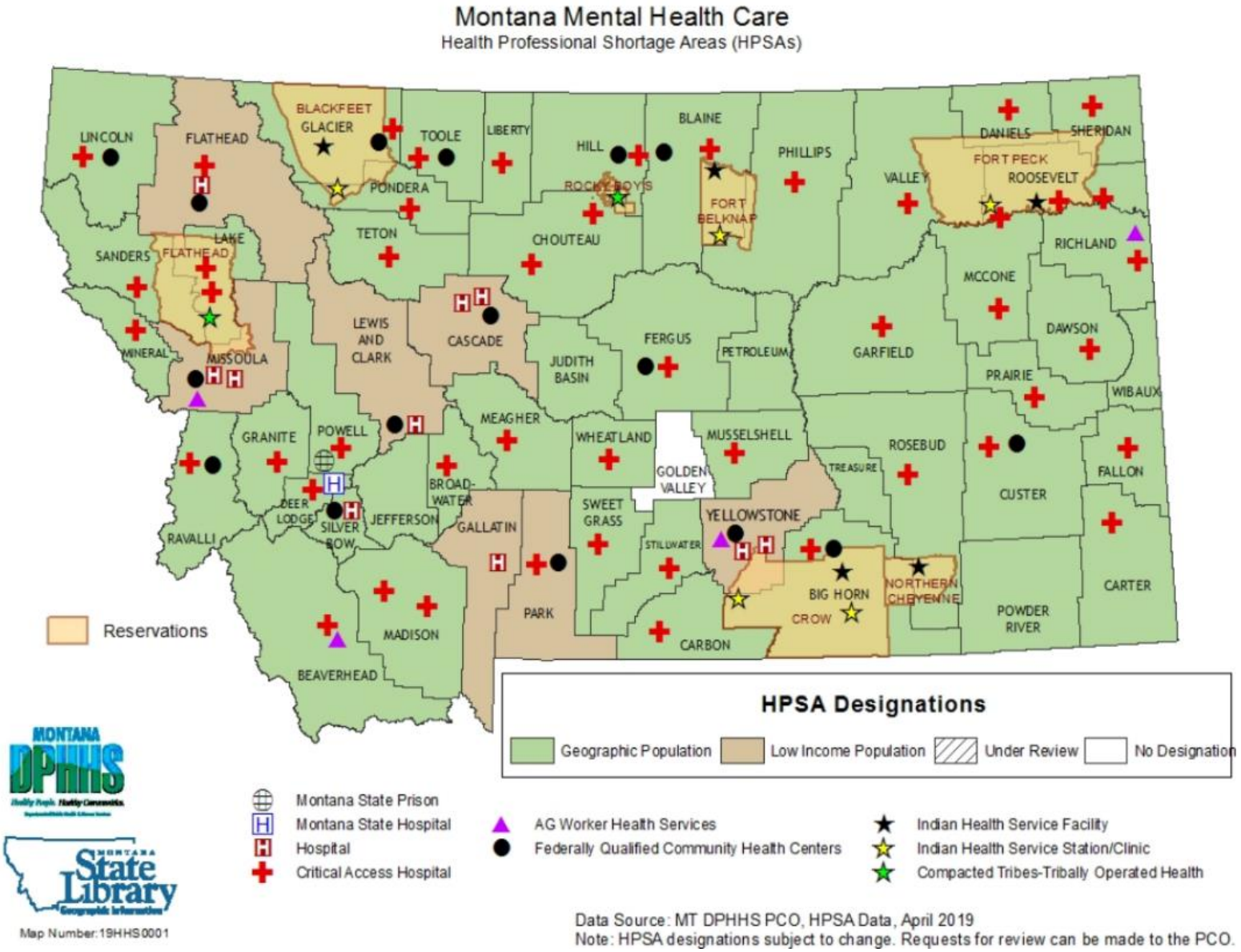
Map 6: ANEW Scholars' Residing Locations, Fall 2020



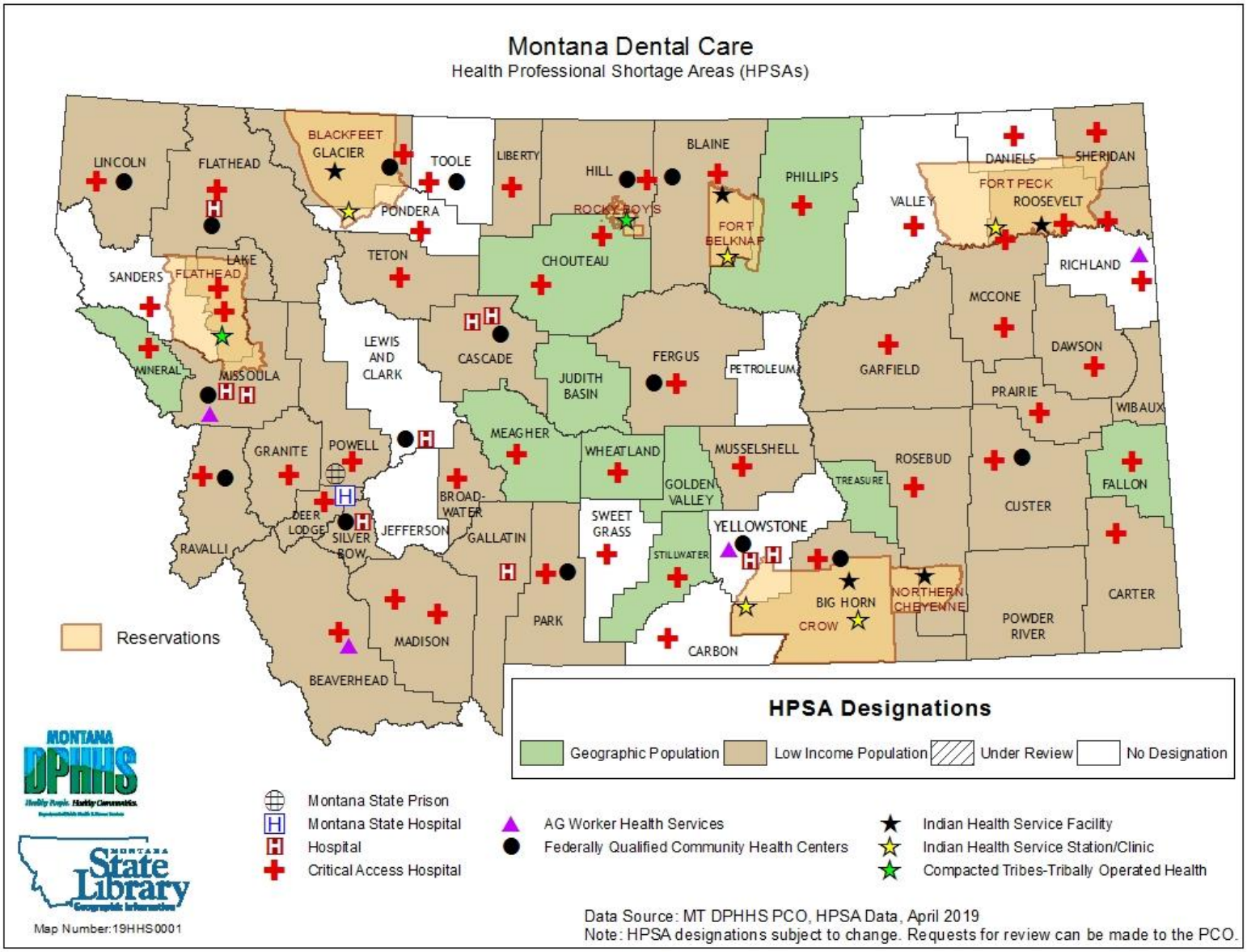
Map 7: Montana Primary Care Health Professional Shortage Area Designation



Map 8: Montana Mental Health Care Health Professional Shortage Area Designation

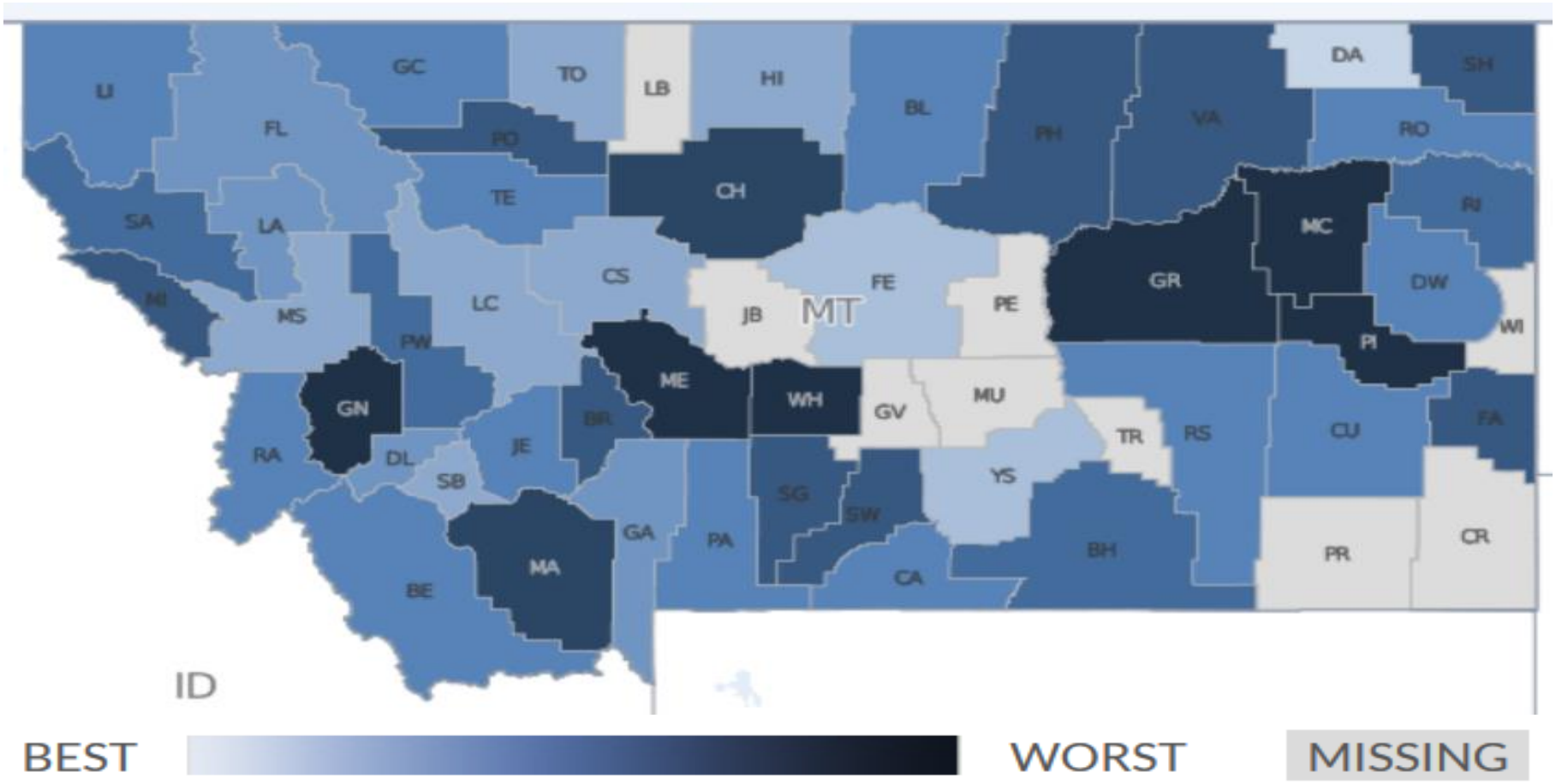


Map 9: Montana Dental Care Health Professional Shortage Area Designation



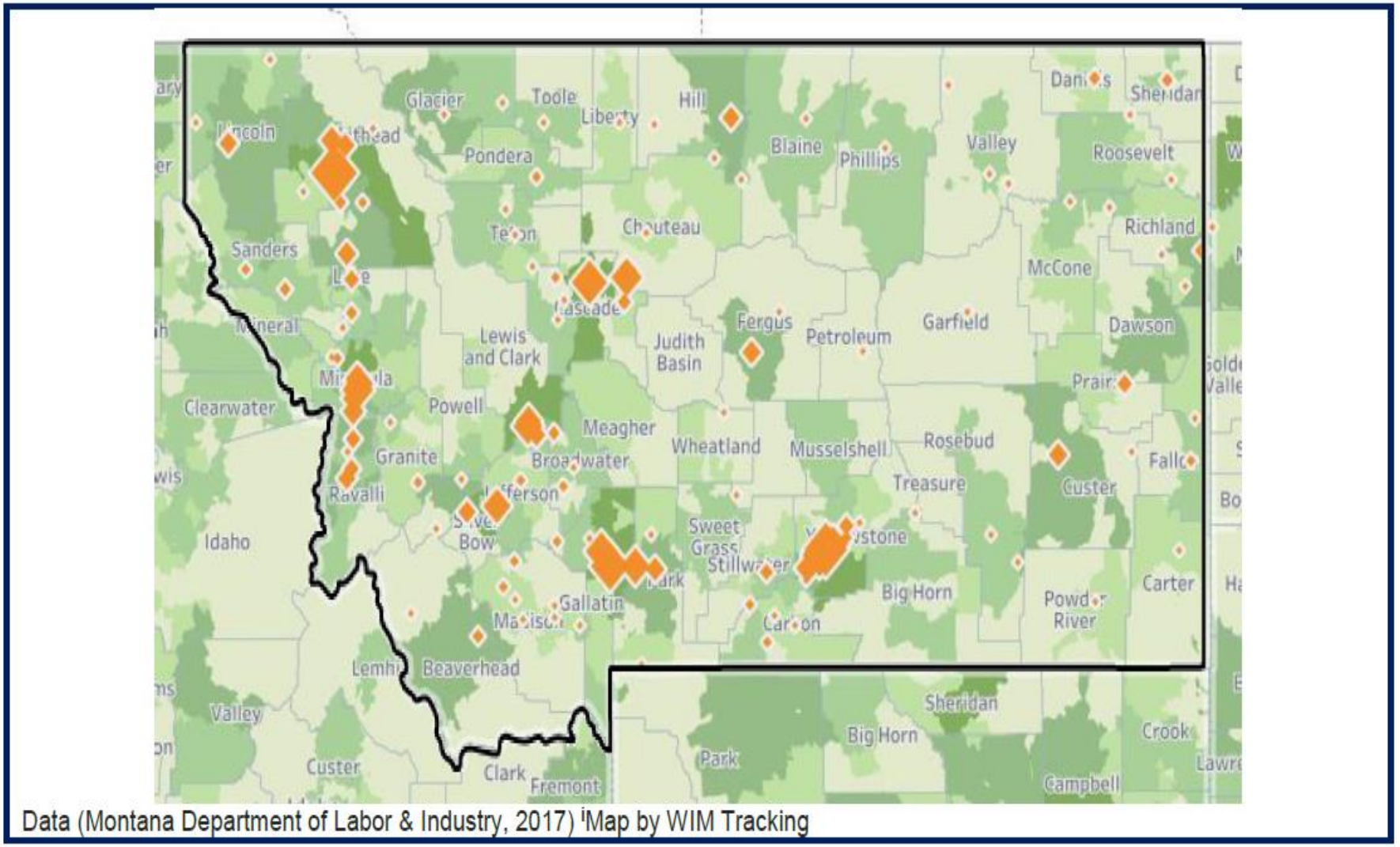
Map 10: Ratio of Population to Dentists, Montana 2017

Ratio of Population to Dentists, Montana 2017



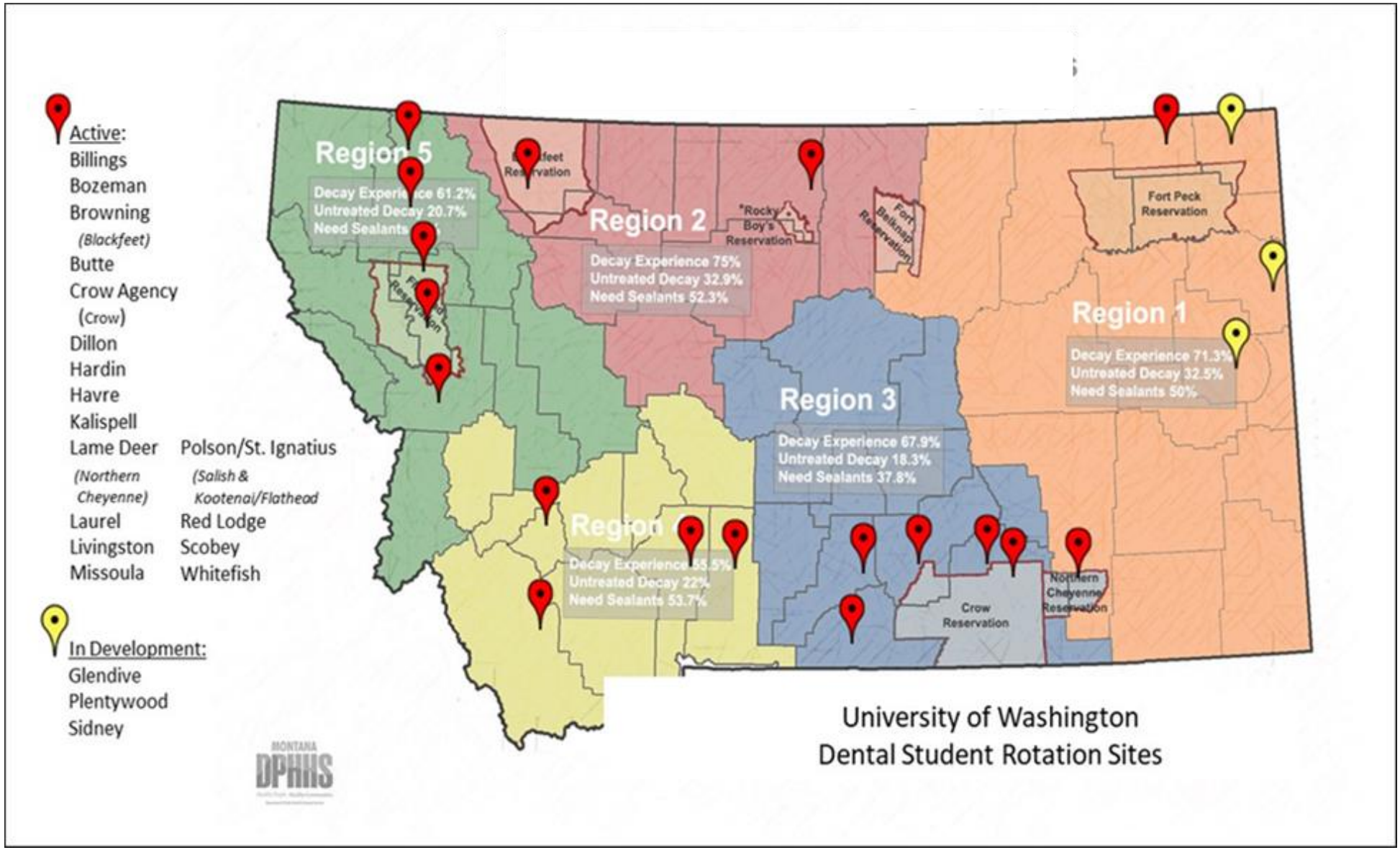
Map 11: Distribution of Montana Dental Hygienists, 2017

Distribution of Montana's Dental Hygienists, 2017

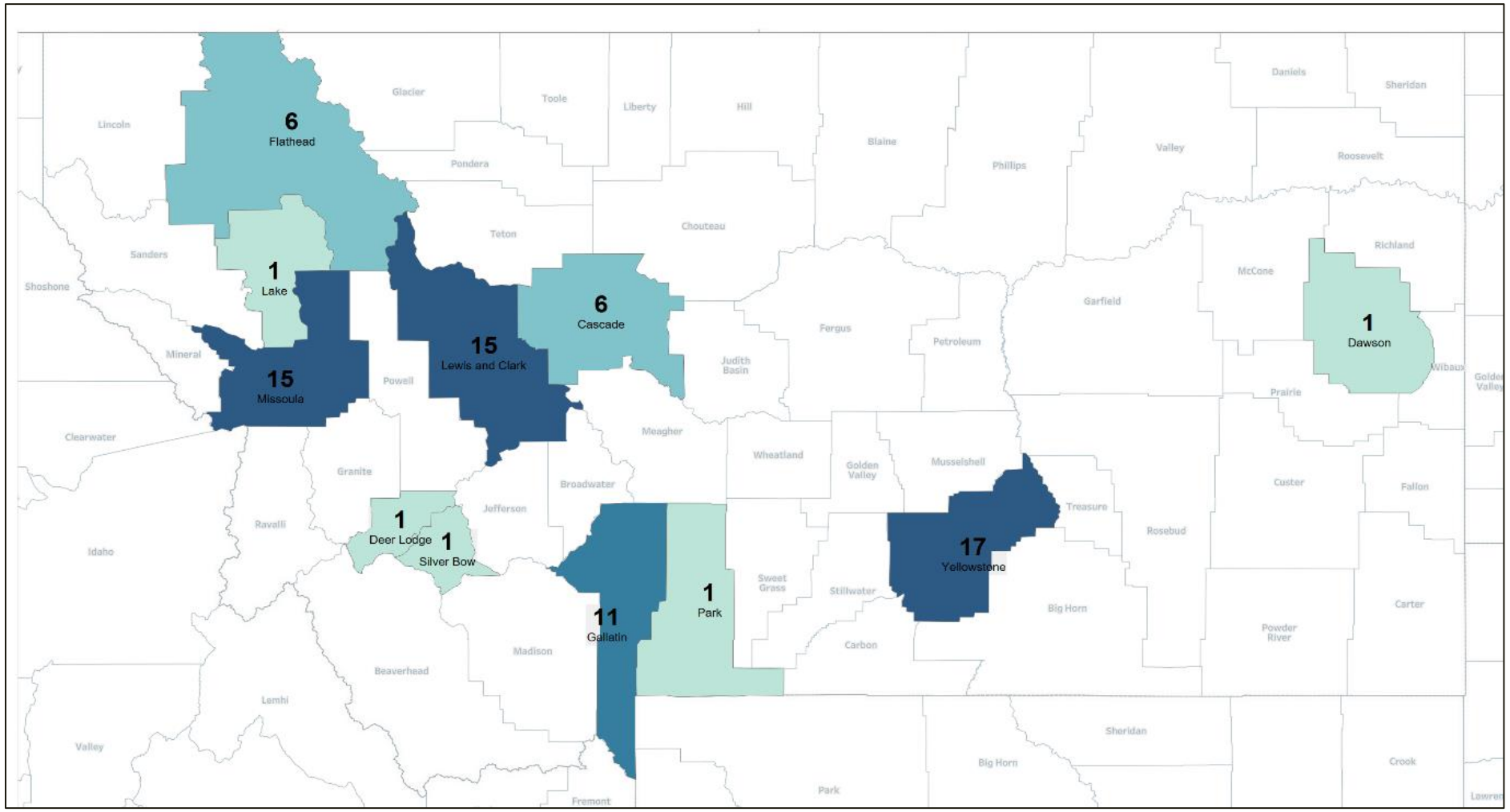


Data (Montana Department of Labor & Industry, 2017) [i]Map by WIM Tracking

Map 12: University of Washington Dental Student Rotation Sites

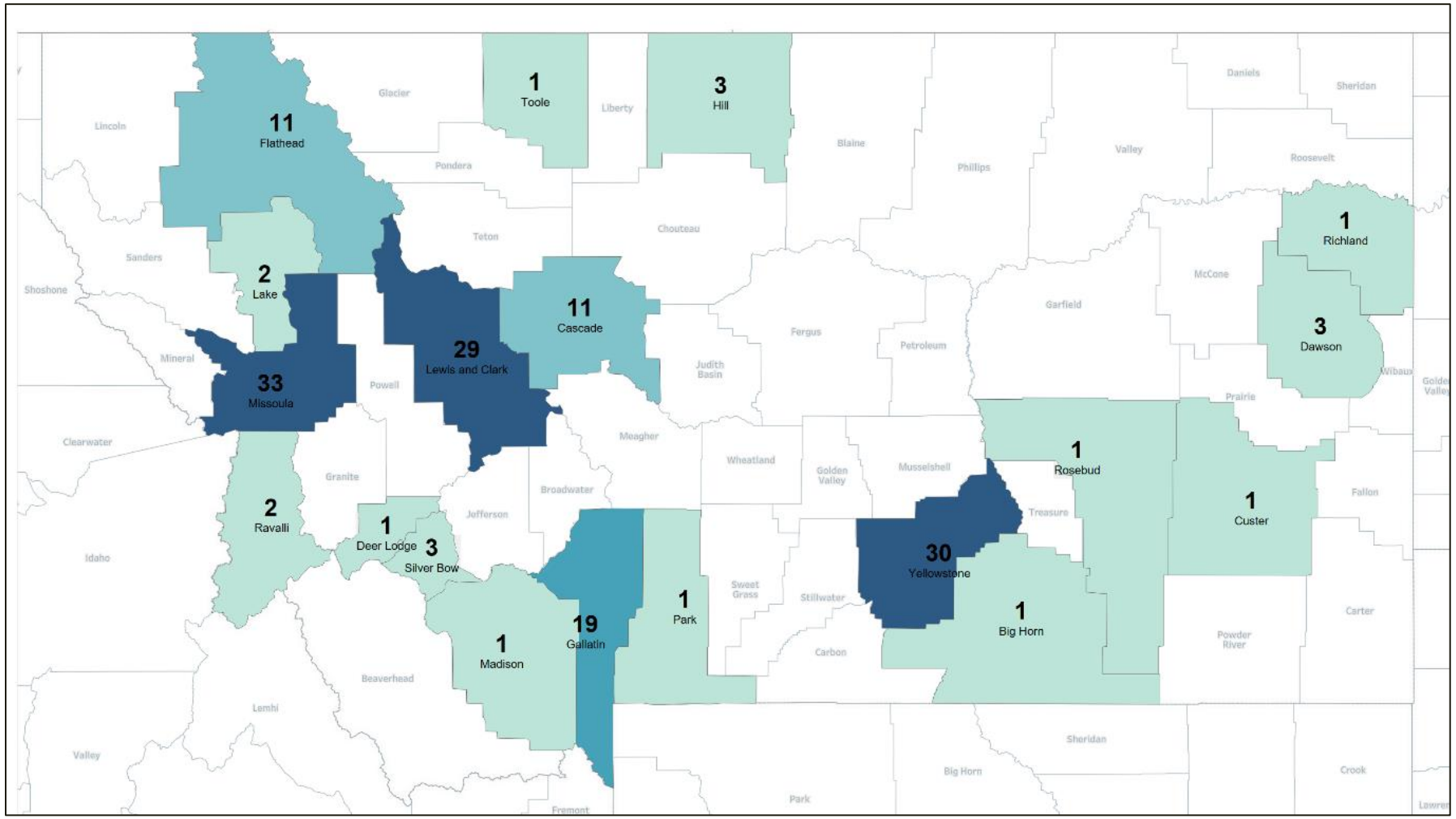


Map 13: Number of Actively Practicing Psychiatrists by County



Data source: WIM Tracking LLC (2020) Data does not include providers within correctional settings, state facilities, Veterans Affairs, or Indian Health Services.

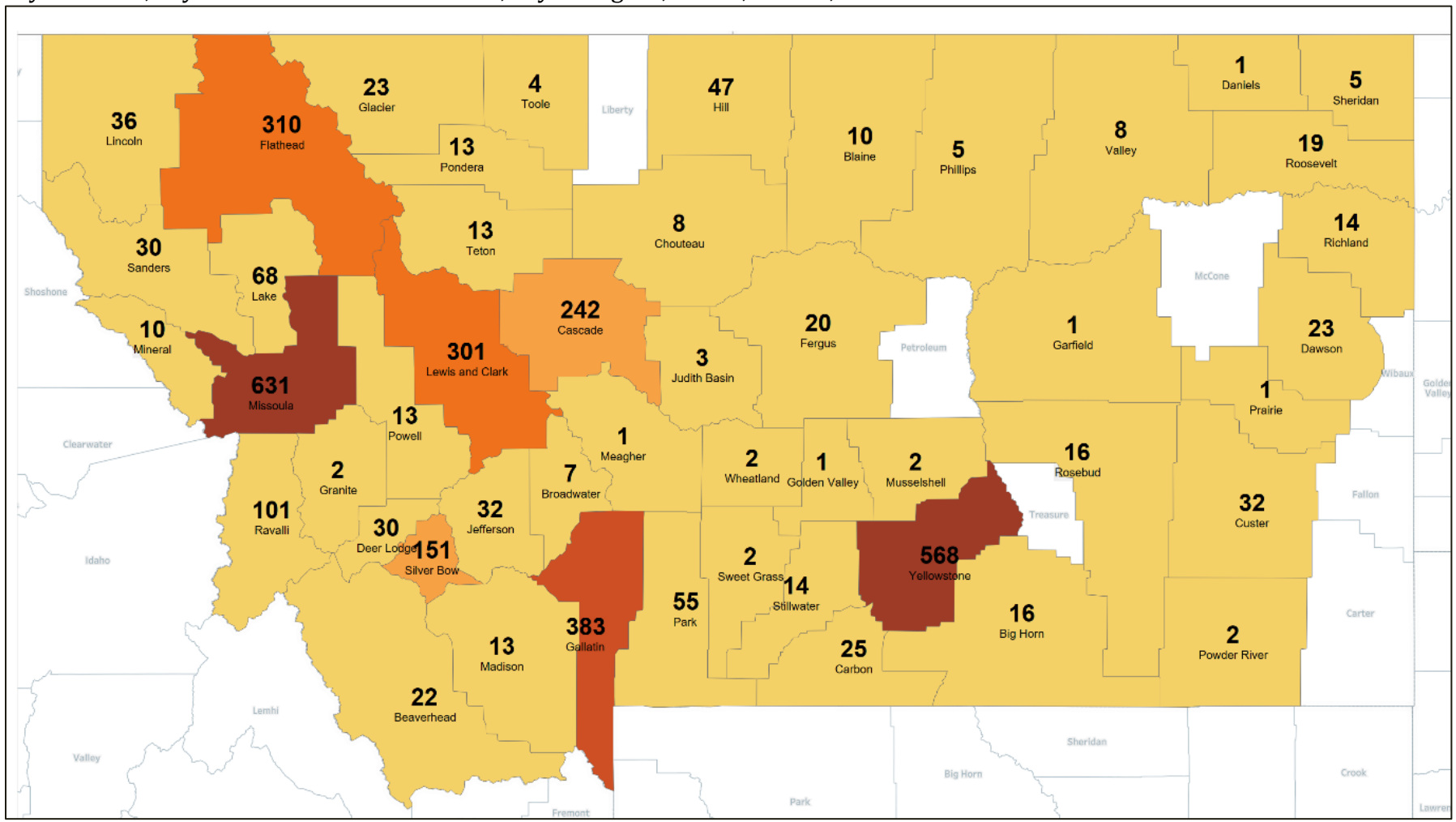
Map 14: Number of Actively Practicing Psychiatrists and Psychiatric Nurse Practitioners by County



Data Source: WIM Tracking LLC (2020) Data does not include providers within correctional settings, state facilities, Veterans Affairs, or Indian Health Services.

Map 15: Number of Actively Licensed Behavioral Health Providers by County

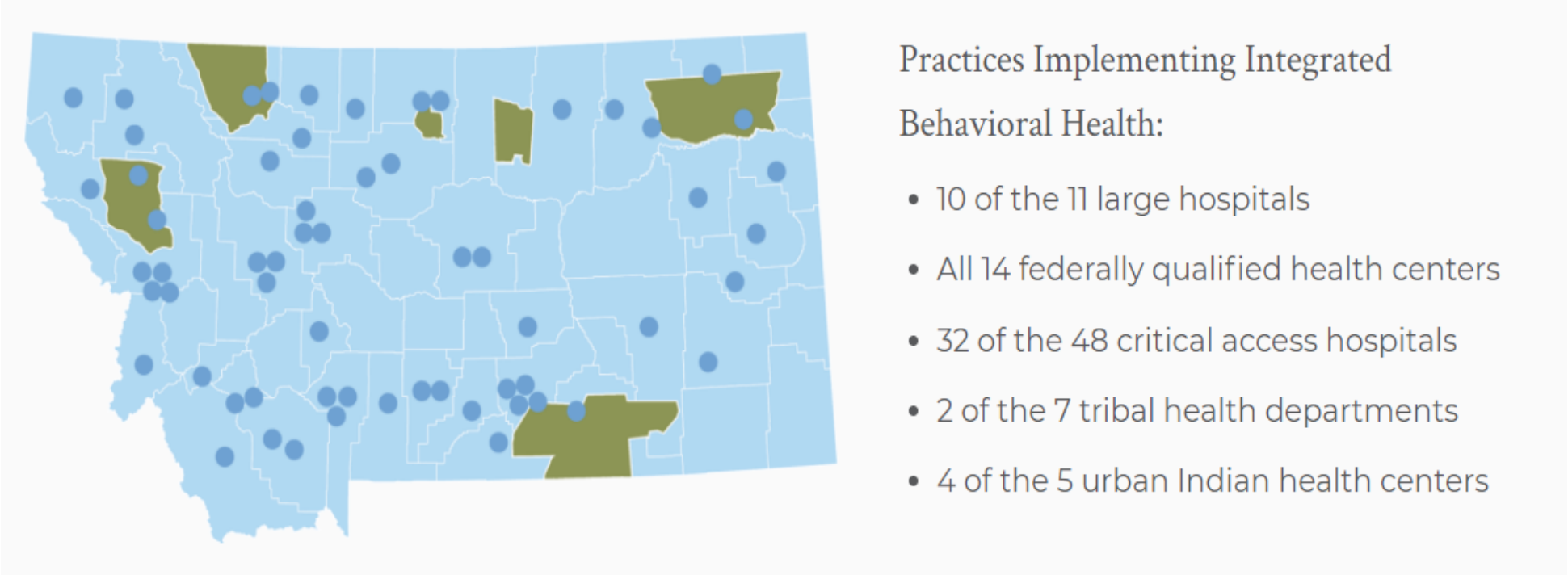
Psychiatrists, Psychiatric Nurse Practitioners, Psychologists, LCPCs, LCSWs, & LACs



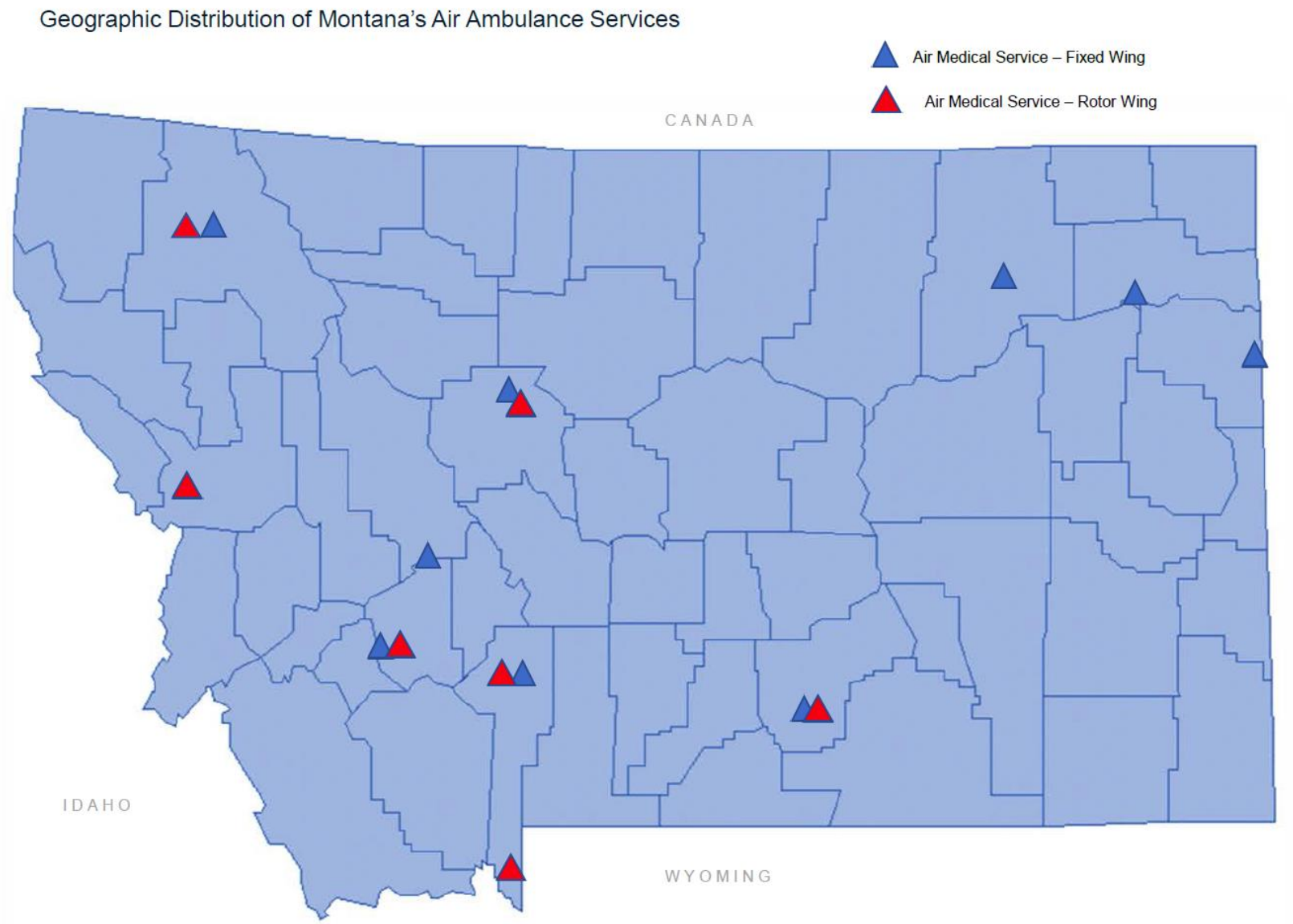
Data source: Montana Department of Labor and Industry Licensing Bureau (April 2020)

Map 16: Practices Implementing Integrated Behavioral Health

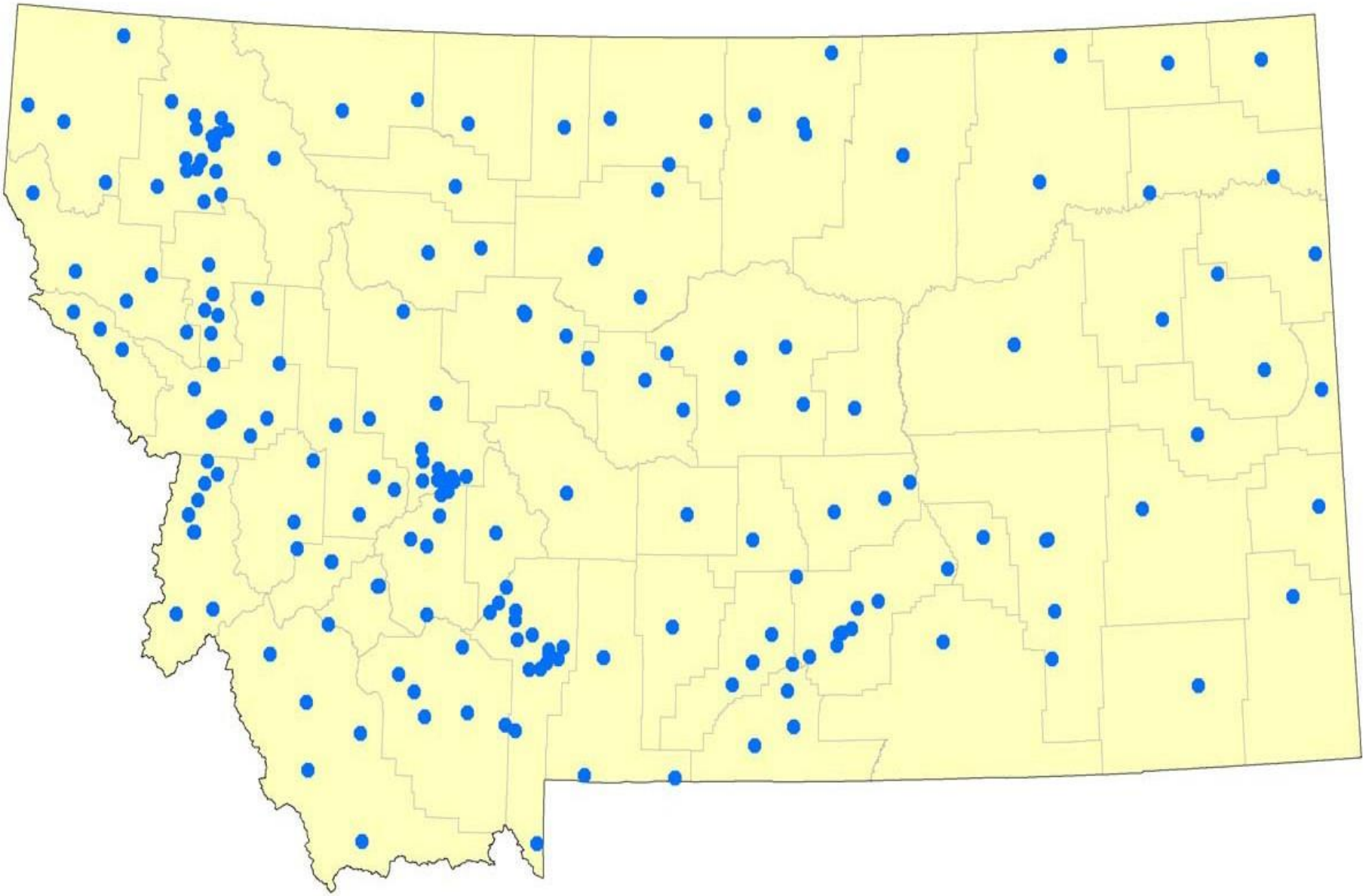
Data source: Montana Healthcare Foundation, 2021



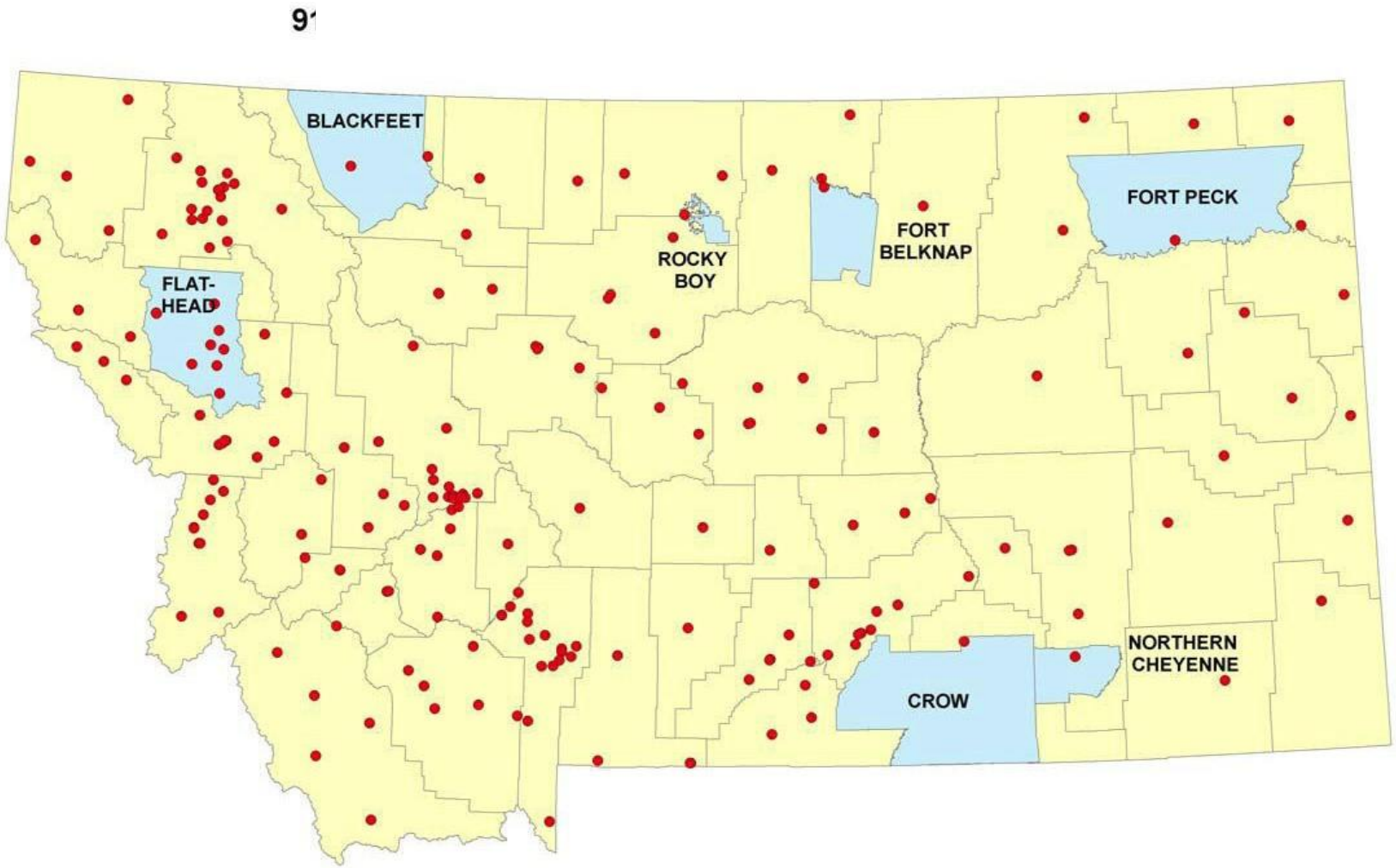
Map 17: Geographic Distribution of Montana's Air Ambulance Services



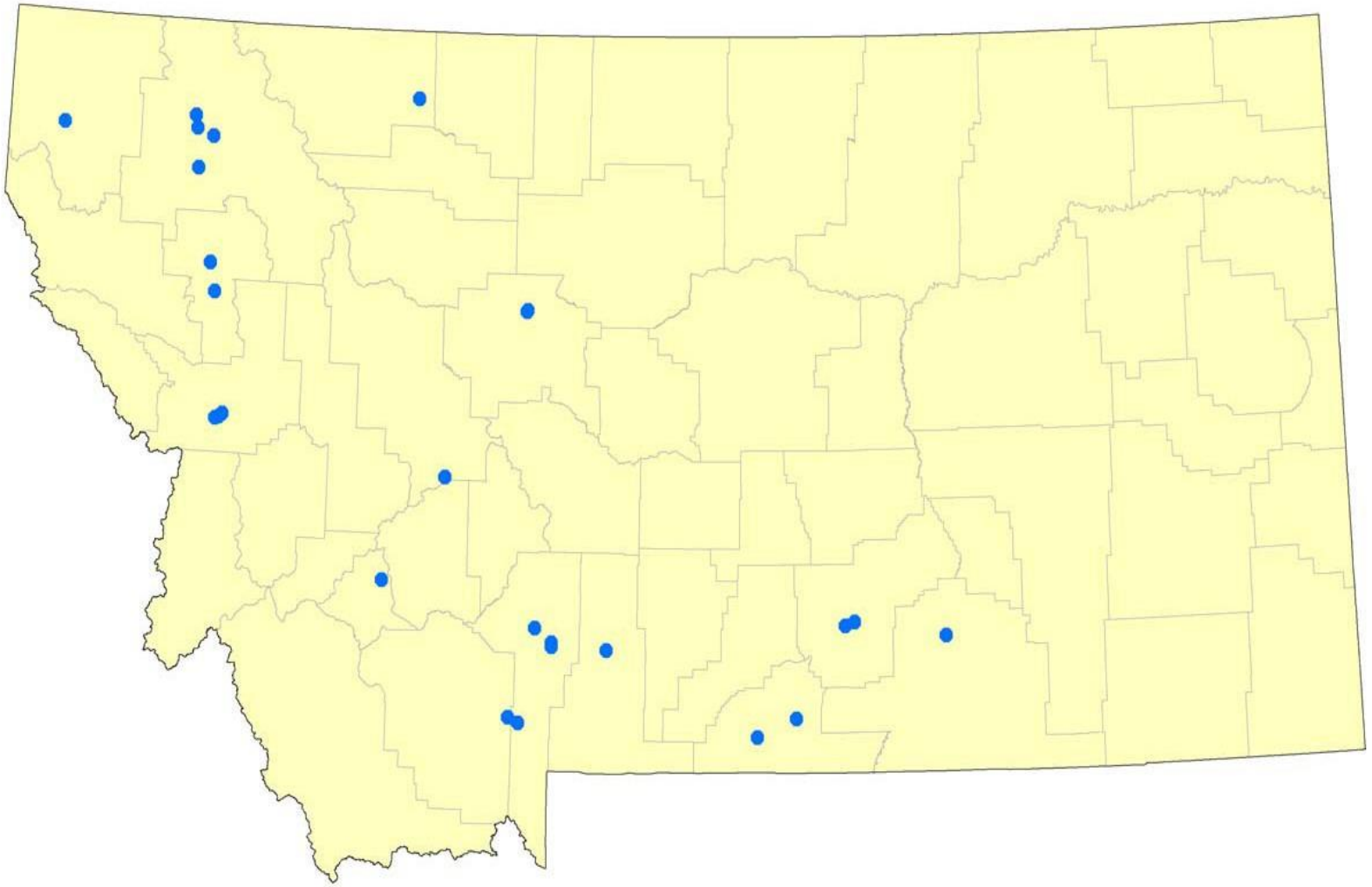
Map 18: Licensed EMS Sites



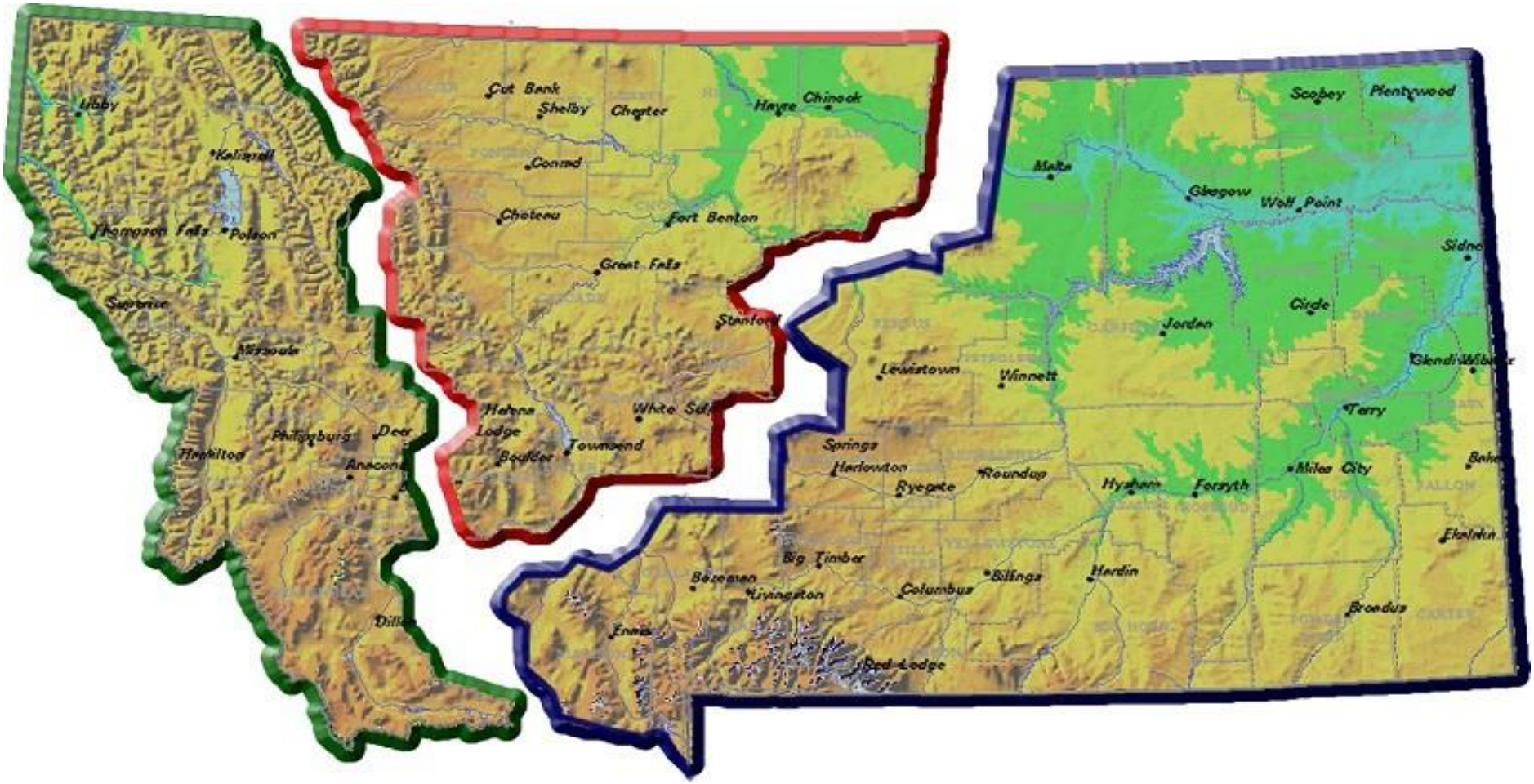
Map 19: Proximity of EMS Units to American Indian Reservations in Montana



Map 20: Emergency Medical Services Advanced Life Support Care 24/7



Map 21: Montana's 3 Trauma Regions



APPENDIX D
Footnotes and Additional References

[1] Wikipedia, Montana Geography http://en.wikipedia.org/wiki/Montana.
[2] http://dnrc.mt.gov/divisions/trust/docs/mt-access-guide, retrieved 6/20/2021
[3] https://data.census.gov/
[4] https://www.ruralhealthinfo.org/topics/frontier
[5] https://montanafreepress.org/2020/03/12/
[6] https://data.census.gov/cedsci/table?tid=ACSDP5Y2019.DP05&g=0400000US30
[7] Senator Conrad Burns, U.S. Senate Floor, December 8, 2004
[8] Distances calculated using http://www.mapquest.com.
[9] Centers for Disease Control, Behavioral Risk Factor Surveillance System Data (BRFSS) State Added Question, "Travel Access To Health Provider," 2005.
[10] United States Department of Veterans Affairs
https://www.va.gov/directory/guide/state.asp?STATE=MT&dnum=ALL
[11] https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf
[12] America's Health Rankings, Montana (2020)
https://www.americashealthrankings.org/learn/reports/2020-annual-report/state-summaries-montana
[13] Ibid.
[14] Henry J. Kaiser Family Foundation, Montana http://statehealthfacts.org
[15] Healthy People 2030 https://health.gov/healthypeople
[16] U.S. Census Bureau https://www.census.gov/quickfacts/MT
[17] Ibid.
[18] Bureau of Business and Economic Research (BBER), *The Economic Impact of Montana's Hospitals,* 2021.
[19] Bureau of Business and Economic Research (BBER), *Medicaid Expansion Impact*, 2018.
[20] https://leg.mt.gov/content/Publications/fiscal/Session-2021/SubCom-B/Section-B-print.pdf
[21] Henry J. Kaiser Family Foundation https://www.kff.org/other/state-indicator/nonelderly-0-64
[22] Montana Commissioner of Insurance, 2016
[23] Montana Department of Public Health and Human Services
https://medicaidprovider.mt.gov/manuals/thip#666657706-introduction
[24] Montana Department of Labor and Industry https://lmi.mt.gov/Home/DS-Results-PROJ
[25] Ibid.
[26] National Council of State Boards of Nursing, https://www.ncsbn.org/2015ExecutiveSummary.pdf
[27] Native American Nursing Education in Montana: A Montana APIN Diversity Report, spring 2015.
[28] Map 8: Montana Mental Health Care Health Professional Shortage Area Designation
[29] Federal Register / Vol. 63, No. 173 /Tuesday, September 8, 1998 / Proposed Rules
[30] Kansas Hospital Association Rural Health Visioning Technical Advisory Group. March 2015. Sustaining Rural Health Care in Kansas, *The Development of Alternative Models*. Topeka, Kansas: Kansas Hospital Association. http://www.healthforum-edu.com/rural/PDF/2016/BendbutDontBreakFlexibleDeliveryModelsforRuralCommunities2.pdf
[31] The Oregon Health Authority oversees the state's Rural Health Reform Initiative. Information about the plan is available at http://www.oregon.gov/oha/pages/rhri.aspx
[32]MedPAC suggests alternative models for rural hospitals. (Fierce Healthcare, October 15, 2015). http://www.fiercehealthcare.com/finance/medpac-suggests-alternative-models-for-rural-hospitals More information on MedPAC's proposals is available at: http://www.medpac.gov/documents/october-2015-meeting-presentation-models-for-preserving-access-to-emergency-care-in-rural-areas-

.pdf?sfvrsn=0
[33] Rural Emergency Acute Care Hospital Act. S. 1648. 114th Congress. (2015). https://www.congress.gov/bill/114th-congress/senate-bill/1648
[34] Save Rural Hospitals Act. H.R. 3225, 114th Congress. (2015). https://www.congress.gov/bill/114th-congress/house-bill/3225/text
[35] Montana Health Research and Education Foundation, 2021.
[36] Ibid.
[37] Montana Healthcare Foundation https://mthcf.org/initiatives/integrated-behavioral-health/
[38] Community-Based Needs Assessment: Assisting Communities in Building a Stronger EMS System, HRSA, Undated
[39] MT DPHHS https://dphhs.mt.gov/assets/publichealth/EMSTS/EMS/EMSSurveyReport.pdf
[40] Darrold Bertsch, CEO, Sakakawea Medical Center, in a presentation proposing improved community relationships between critical access hospitals and federally qualified health centers, Cut Bank Montana, 2020