FY 2012-2013

BLOCK GRANT APPLICATION

Community Mental Health Plan and Report
Substance Abuse Prevention and Treatment Plan and Report

Submitted September 1, 2011

II. PLANNING STEPS

Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Step1: Assess the Strengths and Needs of the Service System to Address the Specific Populations - Response

CRITERION 1 Comprehensive Continuum of Care

Overview and Role of the State's Mental Health System

The Department of Public Health and Human Services (DPHHS) under the Executive Branch of Montana State Government, administers a wide spectrum of programs and projects including public assistance, Medicaid, foster care and adoption, nursing home licensing, long-term care, aging services, alcohol and drug abuse programs, mental health services, vocational rehabilitation, disability services, child support enforcement activities, and public health functions (such as communicable disease control and preservation of public health through chronic disease prevention). ***The Department's mission is to improve and protect the health, well-being, and self-reliance of all Montanans***.

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the public mental health services for children and adults under the Divisions of Addictive and Mental Disorders and Developmental Services are described below in more detail.

Oversight of the divisions is organized into Branches:

Economic Security Services Branch: Provides direct supervision over the Human and Community Services Division, Child Support Enforcement Division, Child and Family Services Division, and the Disability Transitions Program. The branch delivers a broad range of social services to communities in Montana. The branch manager develops an organized approach to family economic security, assists with interdepartmental issues such as system development and tribal relations and develops strategies to manage scarce resources.

Medicaid and Health Services Branch: Provides direct supervision over the Senior and Long Term Care Division, **Developmental Services Division**, **Addictive and Mental Disorders Division**, Health Resources Division, the Medicaid Systems Support Program, and the Healthy Montana Kids Program. The branch provides medical, rehabilitative, and mental health services for Montanans through a variety of programs. The branch manager oversees and coordinates programs and activities of the branch and, as the state Medicaid Director, establishes policy for the Montana Medicaid program.

Operations Services Branch: Provides direct supervision over the Business and Financial Services Division, Quality Assurance Division, Technology Services Division, Office of Budget and Finance, and Office of Fair Hearings. The branch manager develops policy on major issues affecting operations and, as the chief operating and chief financial officer, is responsible for the department's budget, finance, technology, and oversight activities.

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

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

The Child Support Enforcement Division provides federally mandated child support enforcement services. These include locating absent parents, establishing paternity, establishing financial and medical support orders, enforcing current and past-due child support, offering medical and spousal support, and modifying child support orders.

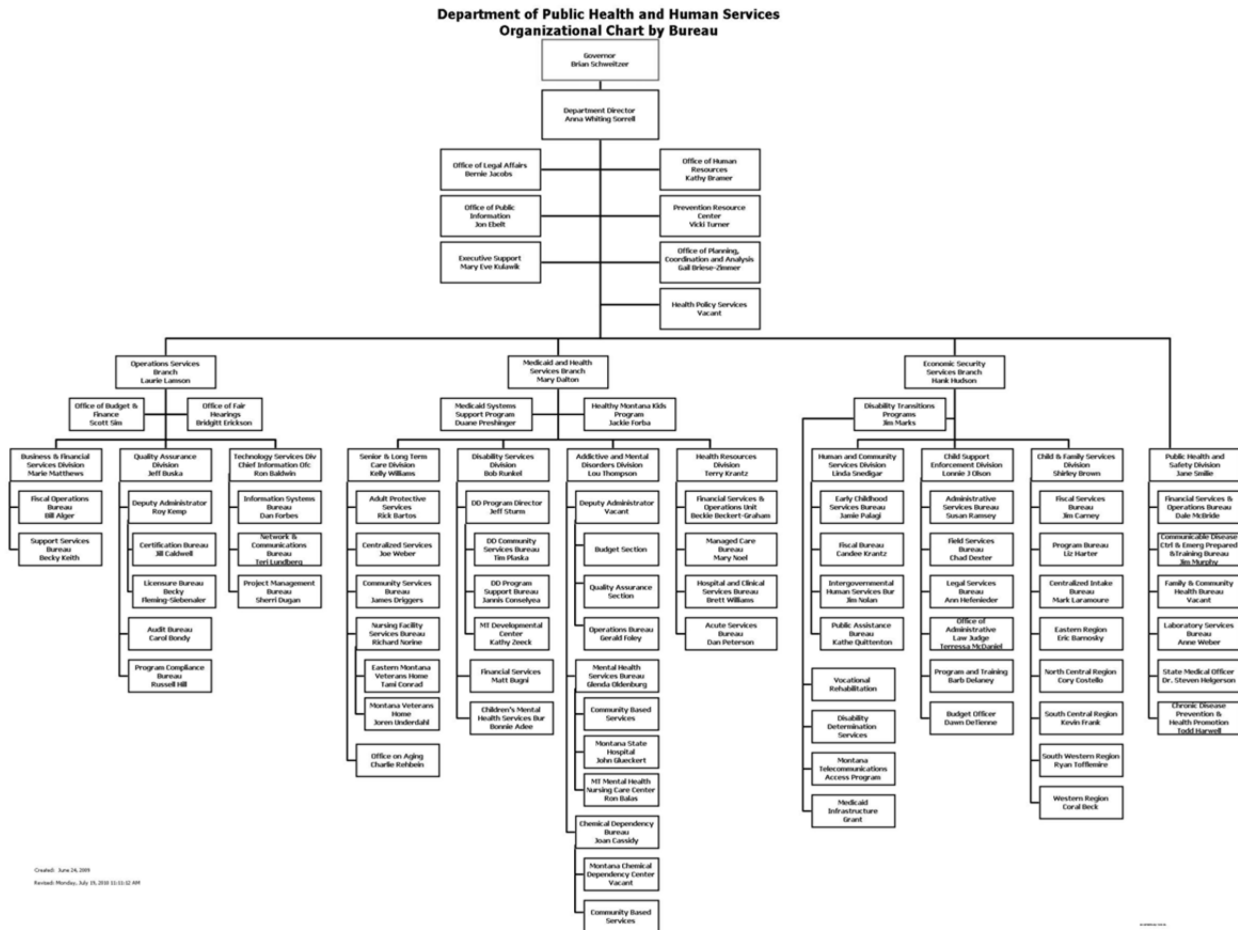
The Disability Transitions Program, under the Economic Security Services Branch, supervises department programs that help people with disabilities find employment and successfully interact within their community. This work is accomplished through the following programs: Blind and Low Vision Services Division, Vocational Rehabilitation, Disability Determination Services, Montana Telecommunications Access Program, and the Medicaid Infrastructure Grant.

Health Resources Division provides preventive and acute health care for low-income and disabled adults and children through Medicaid. Healthy Montana Kids (HMK) is a program under the HRD and provides health coverage to eligible Montana children and teenagers up to age 19. A child can qualify for HMK based on family size and income. Some parents share in the cost of their children's health care by paying a small co-payment when care is received. Covered services include office and clinic visits, emergency services, hospital services, sports or employment physicals, anesthesia services, surgical services, well-child checkups, prescription drugs, lab and x-ray, mental health services, substance abuse services, dental services, vision exams and eyeglasses, and hearing exams and hearing aids.

The Human and Community Services Division's goal is to support the strengths of families and communities by promoting employment and providing the assistance necessary to help families and individuals meet basic needs and work their way out of poverty. They accomplish this by providing cash assistance, employment training, food stamps, Medicaid, child care, meal reimbursement, nutrition training, energy assistance, weatherization, and other services to help families move out of poverty and toward self-support.

The Public Health and Safety Division oversees the coordination of the public health system in Montana. These range in scope from nutrition support and health education (e.g., WIC & Tobacco Use Prevention) to screening services (e.g., breast & cervical cancer screening programs for uninsured women and HIV counseling & testing services) to preventive services (e.g., immunization) and surveillance systems for infectious and chronic diseases, designed to detect and target those health threats that may impact a community.

The Senior and Long-Term Care Division administers aging services, adult protective services, and the State's two veterans' homes. The Division also helps to fund care for elderly and disabled Montanans who are eligible for Medicaid and Supplemental Security Income (SSI). Functions are achieved by providing information, education, and assistance; planning, developing and providing for quality long-term care services; and, operating within a cost–effective service delivery system.



Establishment of System of Care

Montana provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental illness and substance abuse disorders. Available services and resources within Montana's comprehensive system of care are provided primarily with federal and state resources.

Health, Mental Health, and Rehabilitation Services

The Health Resources Division (HRD) of the Montana Department of Public Health and Human Services provides health care for low-income and disabled Montanans through Medicaid. The division provides administration, policy development, and reimbursement for the primary and acute care portions of the Medicaid program.
Medicaid Services Include:
Primary Care
Inpatient and Outpatient Hospital
Prescription drugs
Transportation
Indian Health Service
Durable Medical Equipment
Dental Services

The PASSPORT to Health is Montana's Medicaid Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. The PASSPORT mission is to manage the delivery of health care to Montana Medicaid clients in order to improve or maintain access and quality while minimizing use of health care resources. Approximately 68% of the Medicaid population is enrolled in PASSPORT.

Team Care managed-care services; Team Care is for clients who use more medical services than the average client indicating they need assistance in learning how to use their Medicaid benefits the right way. Clients enrolled in the program receive education about how to get the right care at the right time at the right place.

The Nurse First program, supported by Team Care provides assistance to Medicaid recipients with chronic conditions, such as diabetes, asthma, and heart conditions. Through a telephone hotline, it also helps all Medicaid clients make appropriate decisions about the level of medical care they need in any given situation.

The Health Resources Division (HRD) also manages Medicaid services for Ambulatory Surgical Centers, Freestanding Dialysis Clinics, Federally Qualified Health Centers (FQHC), Rural Health Clinics, and Critical Access Hospitals.

Healthy Montana Kids is a free or low-cost health coverage plan that provides health coverage to eligible Montana children and teenagers up to age 19. A child can qualify for HMK based on family size and income. Some parents share in the cost of their children's health care by paying

a small co-payment when care is received. The plan covers office and clinic visits, emergency services, hospital services, sports or employment physicals, anesthesia services, surgical services, well-child checkups, prescription drugs, lab and x-ray services, mental health services, substance abuse services, dental services, vision exams and eyeglasses, and hearing exams and hearing aids.

First Health Services Corporation (FHS) is a wholly-owned subsidiary of Magellan, Inc., a national corporation providing a full range of risk and fee-based managed care products and services to a broad cross-section of employers, government-funded groups and government agencies in all fifty states. FHS is certified by the Centers for Medicare and Medicaid Services (CMS) as a Quality Improvement Organization, which performs utilization management and care coordination of inpatient, residential and outpatient psychiatric services for the State of Montana. The Montana Department of Health and Human Services has been a FHS customer since 2000.

Employment Services and Educational Services

Addictive and Mental Disorders Division (AMDD) has promoted employment opportunities through yearly Recovery Grants for over four years. AMDD is currently working with Dartmouth University in the area of evidence based supported employment programs. AMDD has established Individual Placement and Supports (IPS)-Evidence Based Supported Employment as a priority for the 2011-2013 Mental Health Block Grant.

AMDD has an established partnership and a cooperative agreement with the Montana Vocational Rehabilitation (MVR) Services Program. The agreement outlines the provision of supported employment and extended/follow-along services through community based psychiatric rehabilitation or case management. This long-standing agreement has served to define terms of service, and provide general guidance concerning the execution of employment services from the Department of Public Health and Human Services through AMDD and MVR. Both entities are committed to strengthening relationships and increasing the incidence of successful, meaningful employment outcomes for persons with mental illness. Cooperative agreements exist between local Vocational Rehabilitation offices and six (6) of the licensed mental health centers to provide supportive and competitive employment services. However, mental health centers, through case management services continue to refer and link consumers to supportive and competitive employment and following along opportunities through vocational rehabilitation offices statewide. Through strength-based case management or person-centered planning processes, vocational or case managers assist clients to identify what they are most interested in pursuing and match those interests with the person’s capabilities. This can include opportunities to pursue and complete General Education or college degrees.

The Mental Health Oversight Advisory Council is partnering with the Mental Health Services Bureau, through the Housing and Employment Taskforce, to review employment goals and indicators in the State Mental Health Plan.

The State of Montana, Department of Public Health and Human Services, is in the sixth year of work under the Medicaid Infrastructure Grant program funded by Ticket to Work and the Work Incentives Act. A broad-based coalition of Montanans is committed to the goals and objectives outlined in this continuing application. The Montana Medicaid Infrastructure Grant project will continue to build on the initial efforts to promote sustainable systems change that will integrate employment opportunities and ultimately help Montanans with disabilities achieve greater self-sufficiency.

The Montana Medicaid for Workers with Disabilities (MMWD) began in July, 2010, as a result of action by the 2009 Legislature. Montana Department of Public Health and Human Services (DPHHS) administer the MMWD program; the MMWD will allow individuals with disabilities to participate in Medicaid, if they are employed above the income eligibility limits for Montana (monthly net household income at or below 250% of the federal poverty level). The Project has contracted with non-profit agencies to provide benefits planning and information on Social Security Work Incentives. The Project Director for the MMWD works closely with the Centers for Medicaid and Medicare, the National Consortium for Health System Development, and other state agencies that have a vested interest in the employment of people with disabilities to provide on-going training/conferences.

Medicaid for Workers with Disabilities participants currently total 425 since implementation in July 2010.

Housing Services

Western Montana Mental Health Center has operated a housing development arm called the Garden City CHDO (Community Housing Development) which has developed over 100 independent housing opportunities for consumers and continues to actively maximize state and federal funds available for the construction of both permanent and short term housing solutions for persons with disabilities. The Center has recently developed a crisis and adult group home facility in Hamilton, has completed construction of a secure crisis facility in Butte, a secure facility in Bozeman, and is in the planning stages for new crisis facilities in Hamilton and Polson.

SCMRMHC (MHC) has one (1) group home for a total of seven (7) adult group home beds and one (1) crises bed. Two (2) cooperative living facilities (coop) house 16 consumers with no assigned staff to the home or program, although it relies on case managers from the PACT and targeted case management programs to make daily contact with the residents. SCMRMHS owns a four-plex with four 2-bedroom apartments for consumers. Currently the MHC is involved in a cooperative venture regarding the 2007 Continuum of Care application. It is possible that the MHC will provide the clinical component in the Safe Haven Project.

Eastern Montana Mental Health Center has two group homes and 8 adult foster care beds. The Center relies primarily on case managers working with consumers to find independent and suitable housing. Eastern Montana is a very frontier area and has consistently been challenged with resource development, including housing. Housing has become even more challenging for those with severe disabling mental illness, with the migration of those seeking employment with oil companies and other industries supporting this ‘boom’ of sorts and holding enough financial

resources to secure housing opportunities that may have been available in the past to those the Center services.

The Center for Mental Health has four (4) 24-hour supervised group homes in Great Falls and one in Helena for a total of 40 beds available for individuals with serious mental illness in need of supervision with the goal of preparing to live independently. There is one 8 bed transitional facility in Great Falls for individuals in need of support after being discharged from an inpatient treatment unit or reintegrating into the community for various reasons such as returning from a military experience. Between Great Falls, Havre and Helena there are approximately 48 beds available in the Adult Foster Care program. All of these individuals in these programs have the availability of case management services, out-patient services, med management, psychiatric assessments, supported employment, crisis services, etc. In Helena there is one crisis home with the capacity of serving six (6) adults and again with a wide array of clinical services available.

AWARE, Inc. has a fulltime housing developer. AWARE has adult group homes available in Butte, Glendive, and Great Falls. The group home housing has followed the universal design and appears as a duplex with common community areas. There is capacity for eight (8) persons for each home.

Community mental health centers utilize shelter plus care vouchers that allow persons with mental illness to access housing in addition to the services available in the community. The communities of Billings, Missoula, Helena, and Butte have access to these vouchers through the public housing authorities. The Department of Commerce, Housing Division is responsible for 18 shelter plus care vouchers. These vouchers are available directly to PATH programs to manage. PATH sites are located in Missoula, Butte and Billings. All FY 2011 PATH sites were provided access to State funded Shelter Plus vouchers through the State Department of Commerce Supportive Housing Program. For the SFY 2010, the Shelter Plus Care Program carried over 28 individuals, accepted 24 new applications for service (a voucher and support services), and were serving 40 individuals by the end of the SFY. Of the new applications received 91% were male individuals and 52% of those were between the ages of 31-50. As clients are moved from the Shelter Plus Care Voucher benefit program to the existing Housing Choice Voucher Program, additional clients are able to be served. The average length of stay for the program was 13-24 months for clients that left the program within the year. Montana's PATH Program provided over $177,000 in required supportive services match for the SFY, with 41% ($73,472) of total supportive services falling under the case management subtype. Over 150 Shelter Plus Care vouchers are available through community public housing authorities.

Substance Abuse Services – Co-Occurring

The Montana Addictive and Mental Disorders Division contracted with Dr. Minkoff and Dr. Cline in 2004, to develop a "train the trainer" curriculum and develop team of statewide change agents to transform the system to meet the needs of clients with co-occurring mental illness and substance use disorders. Through multiple levels of committee structure this initiative has been pushed forward to become an integral element in all aspects of service delivery for mental health and substance abuse.

Each program providing mental health and/or substance abuse services to residents of Montana shall provide a safe and welcoming environment. This will assure that any individual seeking services will feel accepted and respected no matter the reason for which they are seeking help. The physical, technological, and professional environment should be sensitive to issues of compromised capacity, gender, ethnicity and multiple needs.

Each program must adopt specific policies and practices that engage all potential clients into services. The division policy is that all clients can be helped through timely assessment, collaboration and active referral.

All individuals presenting for services in any program will receive integrated screening to identify the presence of possible co-occurring disorders. Each program develop procedures that define how this screening will be conducted for all new client's entering either a mental health or substance related facility so that there is "no wrong door" to treatment access.

Over six percent (6.6%) of Montana's tax on the sales of alcohol is earmarked for the treatment of co-occurring disorders. This money provides mental health services within the addiction service system for those individuals with co-occurring disorders that are not covered by other indigent funding sources. Programs providing these service either have staff available with appropriate services or purchase these services through referral.

Addiction services contracted with AMDD to provide community based residential service must provide its residents with case management service to develop housing and the skills necessary to successfully live independently. The Chemical Dependency Bureau (CDB) funds seven of these facilities. The CDB through federal funding also supports three residential care facilities for women and their dependent children with concurrent treatment as well as three other facilities for adults needing American Society of Addiction Medicine, ASAM level 3.1 care. The incidence of co-occurrence in these residential clients is nearly 100%.

The next step in the implementation of statewide co-occurring capability will be the development of "Train the Trainer" teams. Teams will be developed throughout Montana communities comprised of a Licensed Mental Health Professional and a Licensed Addiction Counselor. The targeted communities are in geographic areas where there is a Block Grant for addictions and a local mental health center. The primary purpose of these trainings is to enhance the communication between the individuals, and subsequently, enhancing the trust and confidence between the two systems.

A variety of materials will be utilized in the training process, with heavy reliance on SAMHSA publications. Follow up training and development of the program will continue through FY 10 and 11. A strategic planning process was held in FY 2010 and is in beginning stages of development and implementation of goals. More information will be provided in FY 2012.

<u>Medical and Dental Services</u>

Each community mental health provider is responsible for assessing the medical and dental needs of each client. Those persons with Medicaid are easily referred and served for their medical needs. However, dental care continues to be an ongoing problem for all persons with

Medicaid. This, in part, is due to concentration of dental services in primary five (5) ‘urban’ areas of the State, leaving very rural and frontier areas un-and under-served. Additionally, dentists often limit the numbers of Medicaid patients they will serve because of the administrative responsibilities related to Medicaid billing.

Persons with MHSP are served through public health clinics and federally qualified clinics that provide medically necessary services for physical and dental health. Medications and limited medical care have been accessed through the federally qualified clinics and Health Care for the Homeless clinics.

Support Services

The Addictive and Mental Disorders Division has supported Mental Health Drop-In Centers for over four years with appropriations from Recovery Grants and general fund appropriations. The Division promotes active centers with recovery focused programs. Consumer run drop-in centers are encouraged and supported.

Individuals with Disabilities Education Act (IDEA) Services

Montana’s goal is for all children with disabilities to receive free appropriate public education (FAPE) in the least restrictive environment that promotes high-quality education and prepares them for employment and independent living, as evidenced by measurable, continuous progress in academic skills and continuous successful participation in school resulting in increased graduation and decreased dropout rates, inclusion in statewide assessments, and the ability to make successful school-to-adult transitions. The Individuals with Disabilities Education Act (IDEA) is the law ensuring that these services are provided to children with disabilities throughout this state and the nation. As part of its general supervision responsibilities under the IDEA, the Office of Public Instruction (OPI) uses its compliance monitoring procedure to ensure that all children with disabilities receive a free appropriate public education in accord with the Individuals with Disabilities Education Act and Montana statutes and administrative rules. As of December 1, 2009, special education services were provided by local school systems under the IDEA to 1,137, (an approximate 4% increase from FY 2008) students with a disability category of Emotional Disturbance as defined by the IDEA and the Administrative Rules of Montana.

Case management Services

Mental health centers are required to collect Recovery Markers—data on employment, housing, symptom interference, substance use and Stage of Change for all consumers receiving case management services. These measures are obtained quarterly by case managers in partnership with consumers and submitted to MHSB through the web-based Recovery Marker program.

Montana has incorporated strengths based and recovery oriented services in the mental health system. The Mental Health Services Bureau (MHSB) continues to provide Illness Management Recovery training opportunities. The MHSB in collaboration with the Chemical Dependency Bureau continues to provide training in the areas of strengths-based case management.

Strengths based assessment and justification of the need for the support of case management must be evident in an individualized treatment plan and team review in addiction services. The Bureau supports the belief that a functional life style is necessary for a healthy recovery.

Montana has a significant Native American population. All of our training events include urban Indian and reservation based programs.

Other Activities Leading to Reduction of Hospitalization

Admission to Montana State Hospital is a judicial process, and the professional staff at the facility do not conduct a pre-admission review or exercise any decision-making authority over the medical necessity for admission. The hospital is licensed for 189 beds. AMDD contracts with First Health Services for an adult care coordinator who works closely with the hospital to ensure more successful community placements. The coordinator is familiar with the community resources across the state and works cooperatively with community providers to creatively wrap those services around persons discharged from the state hospital to ensure a successful transition to community services.

Community Liaison Officers, who are based in the community to mentor current and recently discharged patients from Montana State Hospital, assure consumers are able to get to referred services, and provide assistance in accessing needed services, supports, and resources in the community, and provide community support for meeting the recommendations of the hospital discharge plan and re-integrating into the community.

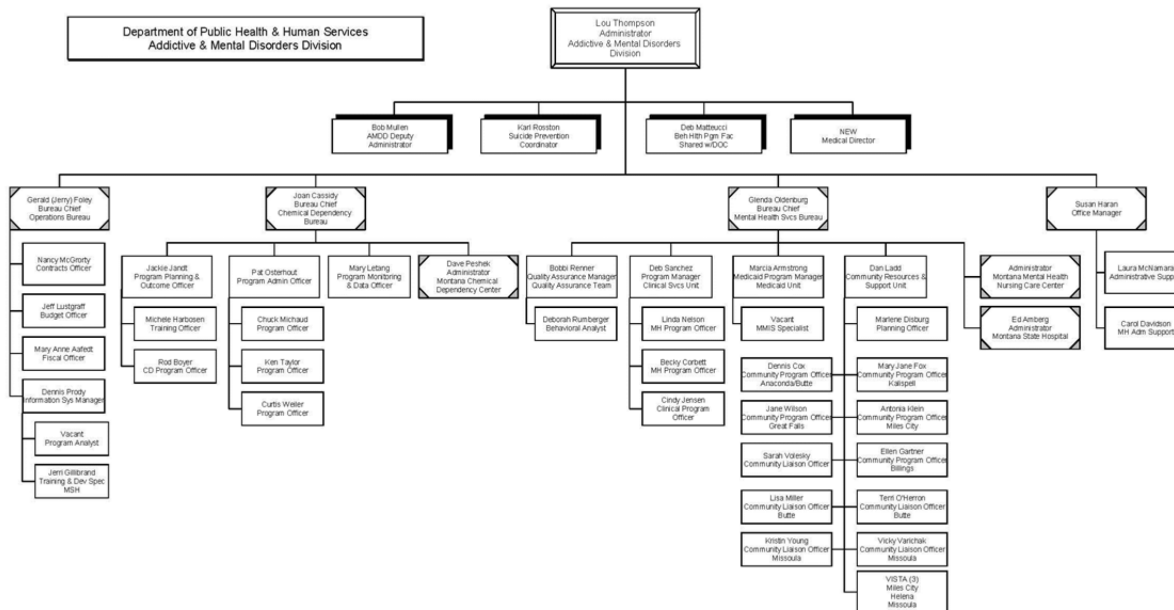
Mental Health - Comprehensive Continuum of Care

The Disability Services and Addictive and Mental Disorders Divisions and associated institutions are directed by the Medicaid and Health Services Branch Director.

The Addictive and Mental Disorders Division (AMDD) is the designated State Adult Mental Health Agency for DPHHS. The mission of AMDD is to implement and improve an appropriate statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol.

AMDD through the Mental Health Services Bureau is responsible for the development and management of the adult mental health system (age 18 and over). The Division provides chemical dependency and adult mental health services by contracting with providers throughout Montana. It also provides services through three inpatient facilities-the Montana State Hospital in Warm Springs, Montana Chemical Dependency Center in Butte, and Montana Mental Health Nursing Care Center in Lewistown.

AMDD has demonstrated a long-term and sustained commitment to persons with severe and disabling mental illness through a broad and evidence-based array of services. The Division is dedicated to collaboration with consumers, family members, providers, and other stakeholders and mental health advocates in the development and annual planning of public mental health services. Community collaboration and coordination is accomplished through the Local Advisory Councils and regional Service Area Authorities.



The Disability Services Division is the designated State Children's' Mental Health Agency for DPHHS. Mental health services for children under 18 are administered through the Disability Services Division, Children's Mental Health Bureau (CMHB). The CMHB was moved from the Health Resources Division in 2009 to provide a seamless transition when children age out of services provided by Children's Mental Health and go into programs offered by Disability Services Division. The Division was restructured under the Medicaid and Health Services Branch of DPHHS. Under this Division services are now provided through two primary programs: the Developmental Disabilities Program and the Children's Mental Health Bureau.

The Developmental Disabilities Program contracts with private, non-profit corporations to provide services across the lifespan for individuals who have developmental disabilities and their families. The focus of the program is to tailor care to the individual and provide it in as natural environment as possible.

The Montana Developmental Center is administered by the Developmental Disabilities Program and is the State's only residential facility for individuals with developmental disabilities that provides 24-hour care for those with the most severe behaviors or severe self help deficits.

The Children's Mental Health Bureau provides care and support to individuals under 18 years of age who have been diagnosed with serious emotional disturbance (SED). Medicaid mental health services include inpatient psychiatric, community-based services such as therapeutic foster care, and community-based outpatient.   A State funded program for low-income youth with 160 percent of the federal poverty guidelines and who are not eligible for Medicaid or Healthy Montana Kids program also provides community-based outpatient psychiatric services, medication management and psychotropic drug assistance.

Separate administration and budgets don't preclude the adult and children's mental health systems from working together, collaborating, and ensuring quality public mental health services. Staff, administrators, parents, and consumers collaborate in meetings, services, and training in efforts to provide adequate services to those in Montana with severe and disabling mental illness and emotional disturbance.

Adult Mental Health Services

The adult mental health system is administered by the Addictive and Mental Disorders Division, (AMDD) through the Mental Health Services Bureau (MHSB).

The Mental Health Services Bureau (MHSB) provides evaluation and technical support to the local and regional planning groups, Local Advisory Councils (LAC) and regional Service Area Authorities (SAA). These groups all have membership requirements that ensure consumer and family member representation. All local planning groups are encouraged to ensure activities are conducted through a broad and inclusive representation of the community mental health system, including community mental health providers, advocates, law enforcement, judicial system, hospitals, and other medical service providers. The Bureau also facilitates and provides administrative functions for the Mental Health Oversight Advisory Council (MHOAC). The Council membership requires participation by LACs through the regional SAAs.

Through the Chemical Dependency Bureau, AMDD assesses the need for chemical dependency treatment and prevention services throughout Montana. Those services are available through contracts with 20 state-approved programs that practice a co-occurring approach to treatment. The bureau reimburses for a full range of outpatient and inpatient services, as well as education programs for DUI offenders and youth charged as a Minor in Possession (MIP).

The Chemical Dependency Bureau also organizes and funds activities designed to prevent the use of alcohol, tobacco, and other drugs by youth and the abuse of those substances by adults. People with substance abuse disorders who have family incomes below 200 percent of the federal poverty level are eligible for public funded treatment services. In addition, the Medicaid program funds outpatient and residential chemical dependency treatment for adults and adolescents who are Medicaid eligible.

The Mental Health Services Bureau is responsible for the development and oversight of the state's system for delivering and reimbursing publicly funded federal funds and state general and special revenue, adult mental health services. The Bureau ensures the availability and efficient delivery of appropriate and effective services. The Bureau also provides extensive monitoring of program implementation and operation as well as analysis and reporting of program operations, costs, and outcomes. Persons eligible for services include adult Medicaid recipients and other low-income Montanans with severe disabling mental illness.

The Addictive and Mental Disorders Division Mental Health Services Bureau has 18 FTE to support administrative, financial, and training for mental health service provision. This includes a bureau chief, a licensed clinician that oversees clinical program development and standards, two quality assurance professionals, six community program officers, a mental health planner,

three half-time and one full-time community liaison officers, and two operations support staff. The Bureau is supported by an Administrator and a Clinical Director (PhD).

AMDD field staff (7.0 FTE), support the development and evaluation of community based services throughout the state. The Community Program Officers (CPOs) foster and support collaborative relationships between the Division (AMDD), the Mental Health Services Bureau and community stakeholders. These stakeholders include consumers, providers, local and tribal governments, legislators, law enforcement, Local Advisory Councils (LAC) and Service Area Authorities (SAA). Community Program Officers represent the Division and Bureau in the community by providing consultation, leadership, and direction on programs and policies; specifically through support and attendance at Local Advisory Council meetings and events. Each CPO works to facilitate and support the planning, development, implementation, and evaluation of community mental health services; identify unmet consumer needs within the public mental health program/system; train and provide local agencies and providers information and support related to evidence-based practices, the state mental health process, state mental health programs; and, collaborate with other state/local and community agencies related to dispute resolution, collaborative mediation and consensus building. Community Program Officers serve as the point of contact for consumer health and safety concerns and also guide and provide oversight for AMDD community based grants.

In addition to the critical role as community liaison and community mental health developer, Community Program Officers (CPOs) are an integral component of the implementation of the Home and Community Based Services Waiver (HCBS) for individuals with severe and disabling mental illness (SDMI). Community Program Officers work with the State's medical review agency for the referral process and nursing home level of care determination, and the waiver community case management team comprised of a mental health case manager/social worker and a registered nurse to provide community wrap around services. The Waiver increased to 19 counties, in 2011. Four of the five CPOs are directly involved in the HCBS Waiver Program and encourage development of waiver services, support providers, and monitor service utilization.

Another critical component to successful community reintegration after hospitalization is AMDD's Community Liaison Officers (CLOs). CLOs provide reintegration support services to individuals who have been discharged from the Montana State Hospital, and to people who have received crisis stabilization services. There are three community liaison officers in three regions. The purpose of the community liaison position is to provide community support for patients discharged from Montana State Hospital to meet the recommendations of the hospital discharge plan and assist with successful re-integration into the community. These duties require that the CLO have expert knowledge of community and natural supports and how to effectively access them in the transition process; ability to facilitate consumer development of personal goals; and, skill to facilitate consumer involvement in community activities and supports that lead to independent living, reduced hospitalization, and recovery.

Medicaid mental health services are provided to adults with severe disabling mental illness (SDMI) through a fee for service system that includes ten (10) licensed mental health centers.

For the adult SDMI population being served by the public mental health system, the workforce development issues continue to be a challenge. AMDD continues to be optimistic about

increased psychiatric workforce development through the APRN Program at Montana State University and the PharmAssist Project There are 40 psychiatrists currently billing under the State of Montana Medicaid System – nine less than prior fiscal year. Medicaid rates most likely contribute to reluctance by psychiatrists to work under the public mental health system.

There are six community hospitals with inpatient psychiatric beds, (6 psychiatric units in state – less than 20% of beds at any point in time are used for public funded individuals) and, 24 Federally Qualified Health Centers (FQHCs), private, not-for-profit, consumer-directed health care corporations which provide high quality, cost-effective and comprehensive primary and preventive care to medically underserved and uninsured people.

The Mental Health Services Bureau administers the Mental Health Services Plan (MHSP) for adults with Severe Disabling Mental Illness (SDMI) who are not eligible for Medicaid and have a family income that does not exceed 150% of the federal poverty level.

The MHSP is a program with a fixed appropriation that must be financially sustainable for the entire fiscal year. AMDD monitors costs and adjusts benefits and enrollment as needed to stay within the available funding. Experiences and challenges over the past four (4) years have moved AMDD to return to modified procedures used in the past allowing providers to have a greater responsibility in assessing client eligibility and supporting financial stability of the program. Mental health centers will receive a contracted appropriation based on historical utilization. Mental health centers that are not responsible for regional service delivery will work closer with the Division for client eligibility and enrollment. The Severe Disabling Mental Illness (SDMI) standards, qualifying diagnosis and functional impairment, for enrollment will be maintained. The limited pharmacy benefit of $425 per month toward the cost of psychotropic medications will be sustained. Screening, identifying psychiatric conditions (assessment) and medication management services will be reimbursable under administrative rule defined physician and mid-level practitioner services. Most of the services provided have limitations.

The MHSP Program is designed to serve individuals who meet SDMI criteria and are:

- in crisis;
- PATH eligible;
- diagnosed with schizophrenia
- young adults in transition from youth services, or
- being discharged from a state facility.

<u>Health Insurance Flexibility and Accountability (HIFA) Waiver</u> – (now titled the MHSP Waiver) Will provide a physical health benefit for individuals up to 150% of poverty, who are eligible for the Montana Mental Health Services Plan (MHSP), and not eligible for Medicare. Montana has chosen to designate a priority population to be eligible for Waiver services. Persons with a diagnosis of schizophrenia will have first priority, with persons with bi-polar disorder being prioritized second. The Waiver will have a cap of 800 individuals in the initial stages.

Community Framework – Consumer Participation

The Montana State Statute, *53-21-702, Mental health care system – eligibility – services – advisory council*, provides the framework for the state public mental health system. The framework **begins at the local level with local advisory councils** that "*report to and meet on a regular basis with the advisory council* (Mental Health Oversight and Advisory Council).

Local Advisory Councils are a coalition of community members interested in planning, evaluating and strengthening their **local** community mental health services. LACs are an integral element to a successful system of public mental health care. *Change begins at the local level.* It is expected that LACs consist of a broad group of stakeholders that represent the community. It is encouraged that stakeholder groups include: Consumer/family members; government and law enforcement officials; mental health service providers, mental health advocates; public health and medical providers, and citizenry that represent the local/regional culture. Each LAC is recognized through representation on the Service Area Authority Board. LACs are the foundation for recommendations to the SAA, DPHHS, MHOAC, on program issues affecting local communities. The Mental Health Services Bureau, through the Community Resources and Support Program developed a Local Advisory Council Handbook to provide guidance and support to new and established members.

Local Advisory Councils (LACs) provide input to the Mental Health Oversight Advisory Council (MHOAC) through the regional Service Area Authorities (SAA) representative on the MHOAC. There are 32 established Local Advisory Councils across the state: Central SAA has 8, serving 15 counties; Western SAA has 8, serving 13 counties; and, the Eastern SAA has 16, serving 27 counties. Due to the large geographical area of the ESAA, the use of video-conferencing is being used to reduce travel costs for the SAA membership.

The alliance of LACs and SAAs in Montana ensures the voice of communities, locally and regionally, is recognized. Local Advisory Councils and Service Area Authorities (SAA) serve as the local network to mental health strategic initiatives in Montana. Both LACs and SAA groups are expected to include representation by consumers and consumer family members. SAA executive boards are required to have 51% consumer and family member representation.

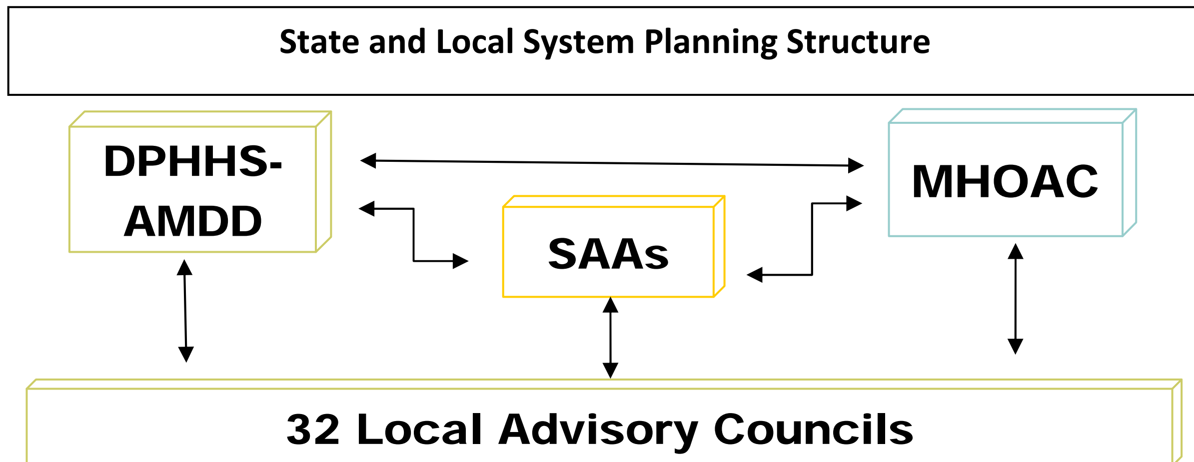
Service Area Authorities are statutorily defined for the purpose of collaboration with the Department for the planning and oversight of mental health services within a service area. Each Service Area Authority has incorporated, adopted by-laws, and an appointed board of directors. Service Area Authorities in collaboration with Local Advisory Councils, including provider and advocacy networks work on a strategic plan that addresses the unique needs of their geographic region and population.

All three SAAs are incorporated and registered with the Secretary of State. Each Service Area Authority appoints a regional Board to provide leadership. Regional SAA Boards meet monthly to collaborate with the Mental Health Services Bureau in planning and oversight of mental health system structure and services. Each SAA holds an annual meeting to elect board members and network. Any person may become a member of the Service Area Congress if they reside within the service area and submit a membership form. Congress members have the exclusive right to

elect the SAA Board. Executive Committees of the three SAAs meet quarterly to collaborate on statewide mental health planning, providing a collective vision.

The Mental Health Services Bureau continues to provide the financial and technical support to sustain the SAA system.

Service Area Authorities provide guidance to the MHSB directly and through the MHOAC for service development and planning.



Each Service Area Authority is represented on the Mental Health and Oversight Advisory Council (MHOAC) through Local Advisory Council membership. The MHOAC is the body responsible under federal statute to *"monitor, review, and evaluate the adequacy of mental health services within the State."*

The Addictive and Mental Disorders and Health Resources Divisions, and their respective mental health service bureaus are represented on the Montana Mental Health Oversight and Advisory Council (MHOAC). Together, with the assistance of the MHOAC Block Grant Committee, the Council and Divisions develop and implement the Community Mental Health Services Block Grant and adult and children's state mental health state plans.

Service Provision – Available Services

Because of the frontier nature of Montana, our entire mental health service plan is essentially a plan for delivery of services in rural and frontier settings. "Frontier" designation is determined through a weighted matrix of population density, distance in miles to a service/market center and travel time in minutes. Over 800 of the country's 3190 counties have been designated as frontier by the Frontier Education Center in consultation with State Offices of Rural Health. Most frontier land is located in Alaska, the Great Plains and the West. Montana ranks number three (3) out of 19 states that account for about 95% of the land designated as frontier. When comparing the Top Ten Frontier States by Population and Area, Montana ranks 6th in Largest Frontier Population and, as noted above, 3rd in Largest Frontier Area. (Footnote: National

Center for Frontier Communities). The entire plan addresses the manner in which mental health services will be provided to individuals residing in rural/frontier areas.

Although concentrating services in the most populated areas would be the most efficient strategy for delivery, Montana has maintained an effort to provide consumers a choice of mental health services in every county in the State. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, and supportive therapy and case management.

Description of Service Providers – Adult

State Operated

Montana State Hospital (MSH) is the only state operated inpatient psychiatric hospital. The hospital provides short-term emergency care as well as extended treatment for adults admitted in accordance with civil involuntary and criminal court (forensic) procedures. Patients are admitted from across the entire state of Montana, often following a short stay in a psychiatric unit in a community hospital, or in a community crisis stabilization facility. State law governs admission and discharge procedures.

The hospital works closely with contracted care coordinators and mental health providers across the state to coordinate care and to return individuals to their home communities for appropriate aftercare services. The hospital has a median length of stay of 38 days for people discharged following civil commitments. Forensic commitments generally have much longer stays.

MSH has an active Resident's Council that has been recognized as one of the best in the country. The Wellness Recovery Action Plan (WRAP) program is in use at MSH and is co-lead by two peer specialists. MSH has also implemented procedures to greatly reduce the use of restraint and seclusion procedures. MSH has played a leadership role in Dialectical Behavioral Therapy (DBT) and Co-Occurring treatment within Montana's Public Mental Health system. MSH has provided many staff members with training in trauma informed care and other important topics such as the use of "person-first" language to help address stigma.

Montana State Hospital direct care staff consists of: 15 social workers; 5 psychologists; 1 psychologist specialist; 2 treatment specialists; 2 substance abuse counselors; 9 psychiatrists; 135.5 psychiatric technicians; 8 recreation technicians; 8 recreation specialists; 5 recreational therapists; 1 occupational therapist; 4 vocational teachers; 2 peer specialists; 44.25 RN nurses; and 25.10 Licensed Practical Nurses. The average daily census for FY 2010 was 185. There were 762 admissions during the year and 750 discharges. The hospital is certified for participation in the federal Medicare and Medicaid programs.

Montana Nursing Care Center (NCC) is the state-operated nursing care facility for individuals with mental disorders. The Center provides long-term care and treatment to people who require a level of care not available in communities or who will not benefit from intensive psychiatric treatment available at Montana State Hospital. The average age for residents is 63.9 years. The average daily census for fiscal year 2010 was 83.

Montana Chemical Dependency Center (MCDC) is administered by the Department of Public Health & Human Services within the Addictive & Mental Disorders Division and is the single state administered in-patient addictions, co-occurring addictions and psychiatric disorders treatment facility.

MCDC models its treatment methods from on-going research into the neurobiology of addiction and related treatment regimens that have transformed the delivery of service. Detoxification services are provided on a standalone basis; provided as needed to individuals who are entering treatment. Treatment is individualized with no defined number of days required or mandatory discharges. An average length of stay is 35-40 days for individuals. Significant to the evolution of treatment at MCDC is the recognition and implementation of integrated treatment for persons with co-occurring addiction and psychiatric disorders. As with other States co-occurring disorders are the expectation not the exception – 75% – 80% of patients suffer from co-occurring disorders. Medication in treatment is now a significant factor in stabilizing and treating individuals with co-occurring disorders at MCDC allowing individuals to more effectively participate in their treatment. MCDC utilizes an interdisciplinary treatment team consisting of physicians, nurses, mental health therapists, addiction counselors and treatment aides. MCDC continues to develop treatment by implementing best practice models such as dialectical behavioral therapy, parenting and trauma related services.

Referrals into MCDC come from the entire state of Montana from community and reservation based programs. Individuals must be referred by a Montana Licensed Addiction Counselor (LAC) and meet the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for this level of care which is in-patient medically monitored treatment. MCDC serves both male and female adult (18 years of age or older) patients in a non-secure, 24 hour, seven day a week, residential environment. This facility serves approximately 700 patients per year.

MCDC is dually licensed by the State of Montana as a chemical dependency treatment facility as well as a health care facility for a 76 bed capacity with six (6) detoxification/medical beds and 70 treatment beds. Funding for the facility is appropriated by the state legislature with funding being from state special revenue alcohol tax as well as federal block grant with a current annual budget of $ 4.5 million.

Community-Based

Montana's community-based mental health services are provided by a variety of local agencies including licensed mental health centers, independent private practitioners, and short-term psychiatric inpatient units in community hospitals. The community psychiatric inpatient units are located in Kalispell, Missoula, Billings, Helena, Glendive, and Great Falls.

Montana currently has eight (8) licensed mental health centers that provide community-based services in fifty-five of fifty-six counties, and approximately 3,000 individuals eligible for Medicaid mental health services. The four regional community mental health centers provide the greatest portion of high-end services for the public mental health system.

Licensed Mental Health Centers

AWARE, Inc**.** provides targeted services to a subset of adults with serious mental illness and development disabilities; young adults transitioning into adult mental health services; and persons who meet nursing home level of care. The services include targeted case management, intensive community-based rehabilitation, and psychiatric services including medication management. Services are provided in Butte, Great Falls, and Glendive (group home services only).

Billings Community Crisis Center serves as a single point of access for people with mental illness and co-occurring mental illness/substance abuse disorders, based on "no wrong door" philosophy, in the Billings area. The Mission of the Center is: *"The Community Crisis Center will provide assessment and referral services to people in crisis who need access to integrated mental health, chemical dependency, and social services."* The Center is a licensed outpatient facility designed to provide crisis intervention services for a period under 24-hours.
Expected community outcomes for the Billings Community Crisis Center include: decreased utilization of acute level of care and emergency departments for outpatient crisis mental health care; decreased suicide rate in Yellowstone County; increase effective use of county and state tax dollars to meet increasing needs of co-occurring population; decreased healthcare spending for co-occurring population; reliable diversion of those with mental illness from local jail facilities; increased community linkages; and, telehealth opportunities to meet regional aspect of need and resource utilization.

The Center for Mental Health (Regional) is a community mental health center that was established in 1974. The Center employs over 300 staff to serve a thirteen county area in North central Montana, with services provided in 22 facilities. The population of the Center's service area is 215,426. The two largest communities in the region are Great Falls (population 56,215) and Helena (population 27,885). The administrative offices are located in Great Falls. The Center provides an array of mental health and co-occurring services to more than 4,800 individuals, over 700 of which are children, ranging from inpatient care at Benefis Healthcare to in-home services and supports across the region.

The Center is in transition to a recovery-oriented service model that recognizes the need to work together with people with mental illness and with other community partners to improve people's lives and to increase their participation in the community. The Center piloted the first certified Peer Support program in Montana and is working with Vocational Rehabilitation to create a model for statewide peer employment training. The establishment of a second PACT Program in Helena brings the total of Center PACT Teams to three.

The Center contracts with Benefis Healthcare in Great Falls to provide over 90% of the inpatient psychiatric and chemical dependency physician services in its Behavioral Health unit. In addition, the Center contracts for the psychiatric management of individuals in the Benefis Skilled Nursing facility. Center physicians also provide the medical direction of these units. The Center maintains a supportive relationship with St. Peter's Behavioral Inpatient Services Program in Helena.

The Center has established a veteran-specific array of treatment services. To facilitate this service array, the Center has created a Military Affairs Division which coordinates access to services for veterans and their families, as well as facilitates improved services and supports to active-duty members of the military and their families. The Center is committed to provide training for its clinical staff to meet the treatment needs of this population.

The Center has implemented an electronic medical record (EMR) that is supported by a regional management information system using high-speed internet connections with all offices in the region. This system has the ability to transmit electronic billing, client service information and medical records in a secure encrypted environment. The Center is a member of the REACH telemedicine network, with the capacity to link directly with hospitals in the Northern Montana Hospital Association, to link with other telemedicine networks through the Montana Telemedicine Network, and to link worldwide through other existing networks.

The Center has entered into partnerships with several other governmental and private nonprofit agencies in recent years. This includes contractual relationships with the Office of Public Assistance, Probation and Parole, Vocational Rehabilitation, Great Falls Pre-Release Services, and Child and Family Services. In addition, the Center has partnership agreements with Easter Seals, as part of the HCBS – SDMI Medicaid Waiver Program. For over ten years the Center has provided space and support to the Voices of Hope, a certified suicide intervention and information and referral center.

The Center has had a long-term partnership with Great Falls Public Schools, The East Helena School District and other child-serving agencies. The Mental Health Center provides Comprehensive School and Community Treatment (CSCT) Teams in 16 schools. The Center is a member of the Cascade County Early Childhood Coalition, which includes over 20 community agencies which focus on the mental health needs of youth under the age of 7 and their families. The coalition is coordinating prevention and early intervention services, including preschool behavioral health screenings, and service coordination. The Center has received a grant from the Montana Department of Public Health and Human Services to develop a model program for mental health consultation to child care providers.

Eastern Montana Community Mental Health Center (Regional) (EMCMHC) serves seventeen (17) counties in the eastern-most part of the state. This is a huge land area (48,588 square miles) with a population density of less than two (2) people per square mile. This service area, which is larger than many states (service area is larger than the state of Pennsylvania), is bordered by Canada on the north, North and South Dakota on the east, and Wyoming on the south. The Center's service area includes two large Native American reservations, the Fort Peck Reservation to the north, headquartered in Poplar; and the Northern Cheyenne Reservation to the south, headquartered in Lame Deer. The Native American population comprises approximately seven (7) percent of the total population of this service area and 13% of the Center's caseload.

EMCMHC offers some level of services in all 17 counties, although some communities are served on a part-time basis by staff traveling from offices in other counties. Targeted case management for adults is available throughout the entire service delivery area. Day treatment services for adults with severe mental illness are provided in Miles City, Glendive, and Sidney.

Adult residential programs, (an adult group home, adult foster care and a level 3 chemical dependency recovery home), are located in Miles City. Services provided throughout the region are: medication management; outpatient psychotherapy services; community rehabilitation and support; emergency services; education and consultation. EMCMHC has a state approved chemical dependency program in 12 of its 17 counties and has co-located Mental Health and Chemical Dependency staff in all of its joint locations. Eastern Montana uses the Telemedicine Network extensively to provide services to rural areas. The Telemedicine Network makes psychiatric care available to all citizens of Eastern Montana and is being used for education and group sessions. The Network presently serves Ekalaka, Miles City, Glendive, Sidney, Culbertson, Colstrip, Baker, Glasgow, Plentywood, Scobey, Terry, Wolf Point, Malta, Forsyth, and Poplar. The Telemedicine Network is used four (4) nights per week to provide chemical dependency treatment groups region wide. Support groups (AA and NA) are held in EMCMHC teleconferencing facilities. EMCMHC has contractual relationships with the VA and the US Probation Service.

South Central Montana Regional Mental Health Center provides comprehensive services in an eleven-county region in south-central Montana. Their administrative offices are located in Billings with six (6) satellite offices providing services to adjacent counties.

The Mental Health Center provides comprehensive services in Billings including psychiatry, psychotherapy, community recovery center, adult residential services, program for assertive community treatment (PACT), targeted case management, an outreach to the homeless program (PATH), and drop-in services. The Center works collaboratively with the Montana Department of Corrections to provide mental health care to the Montana State Women's Prison population. In partnership with the Department of Veterans Affairs, the Center provides services to Veterans who have served in Iraq, Afghanistan, and other conflicts overseas. Two major community resources are the Billings Clinic, which has the state's largest private psychiatric unit for short-term inpatient acute care and Riverstone Health Care which provides primary care services as well as medication management. In addition to these Center services, the Center Medical Department provides regularly scheduled psychiatric consultation to Riverstone Health Care.

The Mental Health Center is a founding partner (along with St. Vincent's Healthcare; Billings Clinic; and Yellowstone City-County Health Department) of the Community Crisis Center in Billings. The Community Crisis Center provides outpatient assessment and referral and helps divert unnecessary presentations at area emergency rooms. The Mental Health Center provides case management services to the Community Crisis Center and PATH outreach services on-site.

In addition, Billings Clinic Behavioral Health (consisting of 9 full-time psychiatrists) partners with the Mental Health Center to provide on-call and psychiatric services to Billings and the Eastern region of Montana.

The Mental Health Center provides a mental health social worker for the Case Management Team for the Home and Community Based Waiver for individuals with severe disabling mental illness (HCBS - SDMI). The social worker is under contract with the Yellowstone City-County Health Department for services provided through the HCBS waiver.

Western Montana Community Mental Health Center (Regional) (WMMHC) serves fifteen counties in western and southwestern Montana. The area is the most populated region of the state with a density of more than ten people per square mile. WMMHC has worked to provide a comprehensive service system in Missoula, Butte, Kalispell, Hamilton and Bozeman. Each of these communities has outpatient psychotherapy, day treatment, targeted case management, psychiatric services, mobile crisis and crisis residential services. Missoula, Butte and Kalispell have PACT programs. Kalispell Regional Hospital and St. Patrick Hospital (Missoula) each have inpatient psychiatric units; and Butte operates a local secure emergency detention facility, the first in the State of Montana. WMMHC provides outpatient therapy and case management services in the other ten counties in the region. WMMHC also provides medication clinics to outlying communities by psychiatrists and APRNs who travel from Missoula, Bozeman, and Kalispell.

WMMHC continues to offer services to youth including outpatient therapy, psychiatric services, case management, comprehensive school and community treatment, family based services, therapeutic group home services and therapeutic foster care.

Peer Support Programs continue to be developed throughout the WMMHC system. Bozeman and Livingston have been operating Drop-In Centers since 2008, with Superior and Plains opening new Drop-In Centers in 2010. The Superior DIC specifically targets those consumers with co-occurring disorders, providing specialized peer group activities for this population. Other new drop-in activities include an 8,000 square foot community garden in Superior, peer led recovery groups in Plains and Superior, jail and ER diversion, IMR groups and community outreach throughout the region. In Missoula, the Adult Services program has rented a small outbuilding very near the campus, where peers are supporting one another in the making of art and soon, the raising of chickens. These services are peer run and offer temporary safety and basic supports for people experiencing mental illness. Peer Programs are essential components for individuals working towards recovery and offer a number of different services in different combinations including information, support, skill building, social networking, advocacy, inspiration and empowerment. WMMHC currently employs a significant number of peers throughout the organization. The agency supports continued education for peers and offers models of support such as WRAP, IMR and Peer Leadership trainings.

The network of mental health centers under the western umbrella serves over 9,800 individuals annually. The center employs over 760 employees throughout all its counties and affiliates. The center also operates a substance abuse affiliate, Western Montana Addiction Services with services in Missoula, Ravalli, Lake and Mineral counties. The center has operated a housing development arm called the Garden City CHDO, which has developed over 100 independent housing opportunities for consumers and continues to actively maximize state and federal funds available for the construction of both permanent and short term housing solutions for persons with disabilities.

New Developments: WMMHC-Bozeman recently completed a campus, which includes an expanded crisis facility (with secure bed capacity), a new drop in center facility, a four unit independent living complex, as well as a new adult service center for Gallatin County. Additionally, WMMHC also expanded substance abuse services by opening Tri-County

Addiction Services that provides chemical dependency services to Deer Lodge, Granite and Powell counties. In January 2009, a consortium of the two hospitals (St. Luke and St Joseph), Lake County and the WMMHC created a full time emergency capacity for Lake County. This program has been very well received by the community and especially by both hospitals involved. On-going collaborative efforts with St. Joseph Hospital have led to an agreement to make nearly three acres of land adjacent to the hospital available for a new WMMHC campus in Polson. The new campus is planned to expand services to include a crisis residential facility and group home beds. Just recently, an agreement was negotiated between WMMHC Butte and WMMHC Bozeman to provide services to the outlying area of Madison County for crisis response services. An agreement has also been reached with Marcus Daly Hospital in Hamilton to donate land for the purpose of building a secure crisis facility similar to the secure programs already operating in Butte and Bozeman.

Other collaborative efforts in Superior have led to a $4,000 grant from the People's Law Center, and a $5000 Child Care Partnership grant, which is being used to provide services using the Oasis Family Support Program, a family parenting, support, and psycho educational program for families with children aged 0-6 years. The Superior office was also the recipient of the 2010 Missoula Job Service Employer's Council Employer of Choice Award. In Lake County (Polson and Ronan) the office collaborates with the Tribe's Suicide Oversight Committee. Staff members do periodic educational presentations to County and Tribal providers, participate in planning and implementing suicide prevention/intervention programs. The Lake County office of WMMHC participates in County, Tribal, and public schools' health fairs, as well as health fairs put on by private businesses, such as Jore Electronics. Staff provides training in suicide prevention to the County jail, and other interested parties as requested. Staff members are core team members of Ronan School Districts Healthy Schools/Safe Students Program, which helps in identifying activities and training to meet the goals of this program. Staff members are also on the Board of the SKC Social Work Program, and provide presentations on working with SED/SDMI individuals in selected Social Work classes.

As mentioned, the Sanders County Office received recovery grant funding from the State of Montana to open a peer run Drop-In Center in Plains. The team has begun individual and group IMR programming in Thompson Falls, Plains and Hot Springs after receiving training in the model. Staff from the Mental Health Center, local law enforcement, the County Commissioners, Clark Fork Valley Hospital, and local clinicians in private practice are continuing to meet and plan a coordinated crisis response program for the County.

The Lincoln County office in Libby participates regularly in the annual community health fair and provides public education and prevention through articles in the local newspaper, with a consumer question format. The office is moving forward with peer support and direction by adapting the day treatment program into more of a peer drop in center.

In 2008, Butte developed a model consumer employment program (Workers Now), which offers employment opportunities to more than 75 persons monthly. To date, Workers Now in Butte has placed 36 consumers into permanent community job placements; served 10 homeless persons; coordinated and linked several consumers into the mental health system; and have hired 5 peers to work in the Workers Now Program offering support and mentoring. This program is now

being implemented in Missoula and will continue to work as a vehicle for people with mental illness to move forward in the process of recovery. Additionally, Bozeman will be submitting a grant to assist with potential supportive services for the Gallatin County area. In Missoula, a therapeutic group home program was redesigned to receive direct discharges from the Montana State Hospital of persons with co-occurring illnesses who require a sober living arrangement to assist in their recovery. The WMMHC has worked extensively with AMDD to reduce recidivism at MSH through creative use of Plan 189 and use of the 72-hour crisis diversion funding. In partnership with the Department of Veterans Affairs the Center provided services to 880 veterans in the past year who have served in Iraq, Afghanistan, and other conflicts overseas.

Staff receive training in trauma treatment offered by the VA and other outside programs. Staff is offering treatment based on Najavitz's Seeking Safety model, as well as CBT and other evidence based therapeutic approaches.

As all behavioral health systems move toward Health Care Reform, WMMHC looks for innovative ways to work with local community stakeholders. Increasingly, WMMHC offices are partnering with other local agencies such as substance abuse providers and community health clinics in an effort to provide more efficient and more complete care to the consumers of these services.

Winds of Change provides strength-based, recovery oriented, co-occurring services for adults with severe and disabling mental illnesses and also works with consumers involved in the judicial system. A team approach is utilized to provide services. Winds of Change provides the following services: Case Management, Community Based Psychiatric and Rehabilitation Services, in-home crisis stabilization for mental health issues with CBPRS, out-patient therapy, psychiatric medication management, IMR, DBT Skills Group, Therapy, and Phone Coaching, two Group Homes, Employment Program, Job Coaching, and a 24 Hour Crisis Line for Winds of Change consumers. Crisis intervention is provided by phone and face-to-face.

Winds of Change developed a pilot project called Montana Intensive Treatment Teams (MITT) early in their development. These teams consist of a Case Manager, two community- based rehabilitation and support staff and a part time Peer Support Specialist. The goal is to utilize existing resources or build on natural supports in the individual's community without having to use a full team of mental health professionals available in each community all of the time. Winds of Change has developed MITTs specializing in Jail Diversion, the needs of the Adult Group Home clients, and parents involved with Department of Child and Family Services.

Montana Community Services Inc. provides intensive mental health services to children and adults; and provides assisted living services to senior citizens. Montana Community Services is a licensed mental health center and works collaboratively with South Central Montana Regional Mental Health Center to provide necessary services. MTCS provides intensive community based rehabilitation services to individuals with significant mental illness who have primarily resided in institutions. MCS also serves young children between the ages of 4 to 15 who have emotional disturbances and require the services of intensive therapeutic youth services. Montana Community Services works closely with physicians and agencies involved to provide quality services. The company operates the Autumn Care Centers, which are licensed assisted living

homes. The Autumn Care Centers, in addition to providing care to senior citizens, provides services to individuals who are enrolled in the mental health Home and Community Based Waiver Services.

Sunburst Mental Health Services is licensed to provide outpatient mental health services to adults and children in Kalispell and Polson (northwest Montana). Services include providing Clinical Assessments and Therapy, Medication Evaluations and Medication Management, Service Coordination (case management) and Community Support (CBPRS). Sunburst has a crisis line to help meet needs after typical working hours. Sunburst provides an Illness, Management and Recovery Group and a Teen Group for young women; a DBT group is being planned. Sunburst Mental Health Services staff include: Medical Director/Psychiatrist, Psychiatric Mental Health Nurse Practioner, Certified Family Nurse Practioner, Licensed Clinical Social Worker (2), and other supporting master's and bachelor's level staff.

CRITERION 2: Mental Health System Data Epidemiology

The estimated (using high and low civilian population with SMI by the National Association of State Mental Health Directors Research Institute) number of adults with serious mental illness in Montana was estimated to be 40,599 in 2009. Comparing our 2009 data with the national estimates the number of adults served statewide by Montana's mental health system in 2009 was 18,523 translating to a 46% penetration rate.

Nationally estimated average prevalence of serious mental illness for Montana is 5.4%. Montana's 2010 population for adults 18 years or over is 765,852. For SFY2010 Montana served 20,097 adults. The number of eligible consumers in need is 5.4% of our adult population, which is 41,356. We served 20,097, which is a 49% penetration rate.

<u>Definition of Severe Disabling Mental Illness (SDMI)</u>

This definition of severe disabling mental illness is based on diagnosis, duration of illness, and level of functioning. The criteria used by Montana are as follows:

> "Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (7)(a), (b), (c) or (d). The person must also meet the requirements of (7)(e). The person:
>
> (a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital (Warm Springs campus) at least once;
> (b) has recurrent thoughts of death, recurrent suicidal ideation, or a suicide attempt, or a specific plan for committing suicide;
> (c) has a DSM-IV-TR diagnosis of:
> (i) schizophrenic disorder (295);
> (ii) other psychotic disorder (293.81, 293.82, 295.40, 295.70, 297.1, 297.3, 298.9);
> (iii) mood disorder (293.83, 296.22,, 296.24, 296.32, 296.33, 296.40, 296.42,, 296.43, 296.44, 296.52, 296.53, 296.54., 296.62, 296.63, 296.64, 296.7, 296.80, 296.89);
> (iv) amnestic disorder (294.0, 294.8);
> (v) disorder due to a general medical condition (293.01, 310.1);
> (vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;
> (vii) anxiety disorder (300.01, 300.21, 300.3); or
> (viii) posttraumatic stress disorder (309.81);
> (d) has a DSM-IV-TR diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least six months or is obviously predictable to continue for a period of at least six months; and

(e) has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at least two of the following:
(i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
(ii) the person is unable to work in a full-time competitive situation because of mental illness;
(iii) the person has been determined to be disabled due to mental illness by the social security administration; or
(iv) the person maintains a living arrangement only with ongoing supervision, is homeless, or is at imminent risk of homelessness due to mental illness; or

(v) the person has had or will predictably have repeated episodes of decompensation.

(d) has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at least two of the following:

(i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
(ii) the person is unable to work in a full-time competitive situation because of mental illness;
(iii) the person has been determined to be disabled due to mental illness by the Social Security Administration;
(iv) the person maintains a living arrangement only with ongoing supervision, is homeless or is at imminent risk of homelessness due to mental illness; or
(v) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes increased symptoms of psychosis, self-injury, suicidal or homicidal intent or psychiatric hospitalization.

Mental Health Services Plan Expenditures by Service

Services	***FY 10 Net Payments****	***FY 11 Net Payments****
Mental Health Center	*$3,293,795*	*$4,206.930*
Licensed Professional Counselor	*$852,927*	*$605,304.30*
Mid-Level Practitioners	*$269,747*	*$225,131*
Psychiatrists	*$676,175*	*$502,101*
Psychologists	*$54,963*	*$ 26,299*
Social Workers	*$415,674*	*$277,831*
Case Management - MH	*$2,021,990*	*$938,128*
Pharmacy Program	*$2,450,033*	*$1,041,065*
Hospital - Outpatient	*$4,065*	*$4,354*
Physician	*$16,115*	*$16,290*
Laboratory	*$3,003*	*$2,255*
Rural Health Clinic	*$4,140*	*$9,784*
Federally QH Center	*$161,715*	*$72,883*
Critical Access Hospital	*$2,963*	*$2,494*
Total	$10,227,305	$7,795,580

Pharmacy program recipient and costs are based on actual paid claims.
Other service cost and recipient counts are based on encounter data.
Source: ACS 701 Reports and ACS Query Path Decision Support Software
Providers have 365 days to file a claim.

The Mental Health Services Bureau administers the Mental Health Services Plan (MHSP) for adults with Severe Disabling Mental Illness (SDMI) who are not eligible for Medicaid and have a family income that does not exceed 150% of the federal poverty level.

The MHSP is a program with a fixed appropriation that must be financially sustainable for the entire fiscal year. AMDD monitors costs and adjusts benefits and enrollment as needed to stay within the available funding. Experiences and challenges over the past four (4) years have moved AMDD to return to modified procedures used in the past allowing providers to have a greater responsibility in assessing client eligibility and supporting financial stability of the program. Mental health centers will receive a contracted appropriation based on historical utilization. Mental health centers that are not responsible for regional service delivery will work closer with the Division for client eligibility and enrollment. The Severe Disabling Mental Illness (SDMI) standards, qualifying diagnosis and functional impairment, for enrollment will be maintained. The limited pharmacy benefit of $425 per month toward the cost of psychotropic medications will be sustained. Screening, identifying psychiatric conditions (assessment) and medication management services will be reimbursable under administrative rule defined physician and mid-level practitioner services. Most of the services provided have limitations.

Mental Health Services Plan - MHSP Clients Served – SFY 2010 by Age and Gender

Age	Female	Male	Total
18-20 years	108	122	230
21-64 years	2921	2629	5550
65-74 years	71	49	120
75+ years	26	8	34
Total	3126	2808	5934

Mental Health Services Plan - MHSP Clients Served – SFY 2010 by Race

Age Groups	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	Hispanic *	More Than One Race Reported	Race Not Available
18-20 years	12		2	1	200	4	1	15
21-64 years	254	9	25	33	4,685	117	35	509
65-74 years	2		1		106		1	10
75+ years	1				26		1	6
Total	269	9	28	34	5,017	121	38	540

*-Hispanic is considered an Ethnicity and is not duplicated in Race Total

Mental Health Services Plan - MHSP Clients Served – SFY 2011 by Age and Gender

Age	Female	Male	Total
18-20 years	91	90	181
21-64 years	2474	2333	4807
65-74 years	74	39	113
75+ years	22	15	37
Total	2661	2479	5138

Mental Health Services Plan - MHSP Clients Served – SFY 2011 by Race

Age	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	Hispanic *	More Than One Race Reported	Race Not Available
18-20 Years	7		2		147	4		25
21-64 Years	222	7	32	12	3,967	92	25	542
65-74 Years	2	1	1		101			8
75+ Years	1				31			5
Total	232	8	35	12	4,246	96	25	580

*-Hispanic is considered an Ethnicity and is not duplicated in Race Total

Based on the current national economic conditions and lack of other strategies for predicting numbers served, we project the 2012 utilization to be close to the same as 2011. Montana's yearly utilization of services has been fairly stable.

CRITERION4: Targeted Services to Rural and Homeless Populations

Targeted Services to Rural Populations

For planning mental health services, Montana is an entirely rural state and its mental health system is a rural/frontier mental health system. The extent to which this mental health system serves Montana's huge geographic area is impressive. The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

Because of the frontier nature of Montana, our entire mental health service plan is essentially a plan for delivery of services in rural and frontier settings. "Frontier" designation is determined through a weighted matrix of population density, distance in miles to a service/market center and travel time in minutes. Over 800 of the country's 3190 counties have been designated as frontier by the Frontier Education Center in consultation with State Offices of Rural Health. Most frontier land is located in Alaska, the Great Plains and the West. **Montana ranks number three (3) out of 19 states** that account for about 95% of the land designated as frontier. When comparing the Top Ten Frontier States by Population and Area, Montana ranks 6th in Largest Frontier Population and, as noted above, third in Largest Frontier Area. (National Center for Frontier Communities). The entire plan addresses the manner in which mental health services will be provided to individuals residing in rural/frontier areas.

Concentrating services in larger areas may be the most efficient strategy for delivery; however, Montana has maintained an effort to provide consumers a choice of mental health services in every county in the State primarily through the community mental health centers. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, and supportive therapy and case management.

Services to Those Who Are Homeless

The Projects for Assistance in Transition from Homelessness (PATH) programs supports SAMHSA's Strategic Initiates; specifically Recovery Support. Three major mental health centers are asked to concentrate service delivery in the areas of Outreach services, Screening and Diagnostic Treatment services, Community Mental Health services, Case Management services, Referral for primary health services, Job training, Educational services, and relevant Housing services. Enrolled individuals will all be provided the opportunity to transition to community mental health center services as soon as eligible and the PATH program can ensure service stability for the individual.

The PATH program is critical to provide the outreach necessary for those experiencing severe and persistent mental illness and homelessness to access the mainstream public mental health system and accompanying community mental health services.

The Stepping Stones To Recovery SSI/SSDI Outreach, Access And Recovery (SOAR) Initiative is part of the contractual requirements under the PATH contracts.

In collaboration with the State Disability Determination Services, the Human and Community Services, and Addictive and Mental Disorders Divisions with the Department of Public Health and Human Services, as the SOAR State Lead, the State PATH Coordinator helps coordinate SOAR trainings statewide to community mental health center case managers and other organizations serving persons who are homeless or at risk of homelessness. Montana is unique and privileged to have highly expert trainers, including: the Executive Director of Disability Determination Services Division-DDS is the agency that participates with the Social Security Administration to determine disability eligibility in Montana; and, the Montana Coalition for the Homeless Coordinator, a newly forming not-for-profit agency with the mission: *"To educate and advocate in support of preventing and ending homelessness."*

Housing services are an integral component of the PATH program and critical to recovery for persons with severe disabling mental illness or co-occurring disorder.

The Montana PATH Program works closely with the Department of Commerce Shelter Plus staff in the areas of reporting for match requirements and housing grant opportunities. Community mental health centers utilize shelter plus care vouchers that allow persons with mental illness to access housing in addition to other housing the services available in the community. All FY 2011 PATH sites were provided access to State funded Shelter Plus vouchers through the State Department of Commerce Supportive Housing Program.

CRITERION 5: Management Systems

The Addictive and Mental Disorders Division Mental Health Services Bureau has 18 FTE to support administrative, financial, and training for mental health service provision. This includes a bureau chief, a licensed clinician that oversees clinical program development and standards, two quality assurance professionals, six community program officers, a mental health planner, three half-time and one full-time community liaison officers, and two operations support staff. The Bureau is supported by an Administrator and a Clinical Director (PhD).

The Mental Health Services Bureau community program officers work in local communities to plan for and help facilitate the implementation of crisis services through provider agencies. The MHSB works closely with the SAAs, LACs, the Mental Health Oversight Advisory Council, county and city officials, providers and other stakeholders to develop and improve crisis services.

Another model used for crisis is the Crisis Response Team (CRT). Members of the team are dedicated clinicians whose job is to respond to crisis calls in the community, at the local emergency room, or in the detention center. Teams are operational in Kalispell, Missoula, Butte, Helena, and Bozeman/Livingston. Each of the local mental health agencies and chemical dependency programs train first responders in mental health crisis. Many of the emergency rooms contact either the CRT or trained CIT officers when a person in a mental health crisis presents.

The Data Infrastructure Grant (DIG) is awarded to states to assist in the development of a data infrastructure to collect specific data on the population served in the public mental health system. The Uniform Reporting System allows for the exchange of state and federal data for planning purposes and demonstration of effectiveness.

DPHHS has a Drug Utilization Review Board to improve prescribing practices for mental health prescription drugs. The drug utilization review board contracts to provide education on best practices for prescribing.

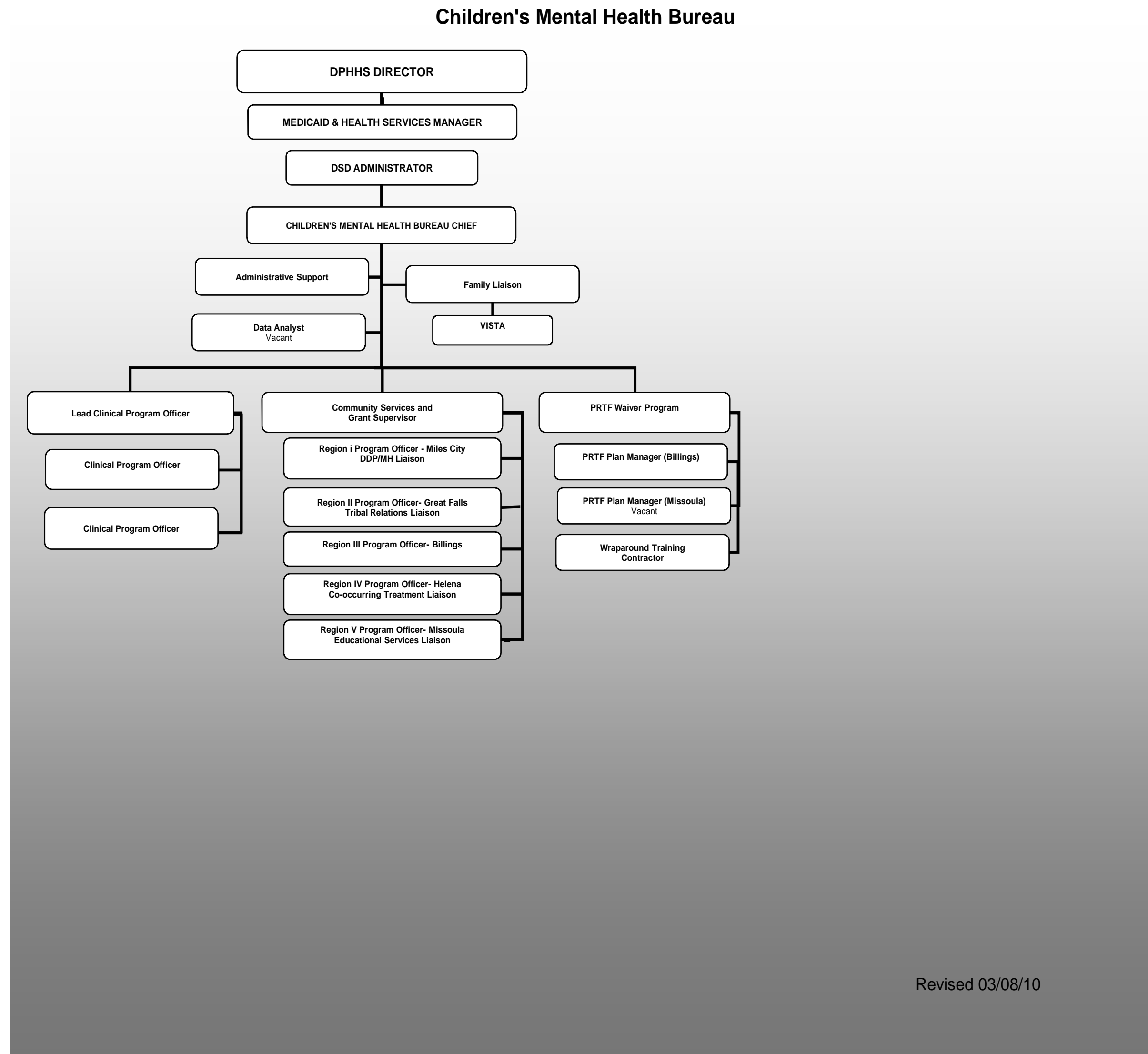
Training: Addictive and Mental Disorders Division (AMDD) collaborated with the National Association of State Mental Health Program Directors (NASMHPD), National Consumer Supporter Technical Assistance Center (NCSTAC) to provide Consumer Leadership and Advocacy Training in Montana. Trainings were provided in major communities, in Montana (Billings, Butte, Kalispell, and Missoula), A total of 59 participants completed the training.

AMDD provided two basic Illness Management and Recovery (IMR) Trainings in 2011 and an IMR Train the Trainer module. The IMR Trained Trainers will be embedded in the mental health centers and provide the foundation for on-going training and support (11 train the trainers). A total of 65 participants attended the IMR basic training.

PACT Team Leader Training
Dialectical Behavior Therapy Basics Training (2) - Dialectical Behavior Therapy for Clinicians
Co-Occurring Transformation Meetings (3)

Children’s Mental Health

The Children’s Mental Health Bureau is in the Developmental Services Division under the Medicaid and Health Services Branch. The Developmental Services Division also includes the Developmental Disabilities Program. Below is the Children’s Mental Health Bureau organizational chart.



CMHB manages public mental health services for children under 18 and advocates for a system of care focused on service delivery in the least restrictive, most appropriate, culturally competent, community-based setting. Respect for the preferences and rights of youth and family members in care planning, service design and delivery and system development is highly valued.

Montana's Medicaid program for children is called Healthy Montana Kids Plus or HMK Plus. Through the Medicaid program, the Bureau manages the following services for children who are seriously emotionally disturbed:

- Inpatient psychiatric services provided in hospital settings or residential treatment facilities; outpatient partial hospitalization programs in some locations
- Community-based services, such as therapeutic foster care and therapeutic group homes (not including room and board expenses);
- Mental health center community-based outpatient services, including individual, group and family therapy; psychotropic medication management; assessment; case management; youth day treatment; community-based psychiatric rehabilitation and support services (CBPRS); and comprehensive school and community treatment (CSCT); and
- Services provided by mental health professionals, including licensed psychologists, licensed social workers, licensed certified professional counselors, advanced practicing RN's; and licensed psychiatrists or medical doctors.

The Children's Mental Health Service Plan, limited to low income youth with SED within 160% FPL who are ineligible for other funding, is managed by a clinical program officer in CMHB. The plan provides community-based, outpatient psychiatric services and psychotropic drug assistance.

CMHB's four Regional Program Officers help develop and support community-based alternatives for youth with SED at risk of placement out of their communities and provide oversight of discharge planning for youth with SED with complex needs returning from PRTFs.

They participate in community planning groups that address needs of youth with SED, assist with monitoring quality of services, address inquiries, concerns, and complaints from families, and manage the Supplemental Services Program (SSP) that uses TANF Maintenance of Effort funds and SOCA (state funded System of Care Account) funding requests. SSP and SOCA are sources of flexible funds for services needed by eligible SED youth that are not available from any other source. CMHB's Family Liaison officer develops Parent Empowerment and Advocacy Conferences, works with MT-NAMI to offer NAMI Basics Train the Teacher training in order to increase the availability of NAMI Basics classes to families across Montana and provides staff support to the parents who chair the SOC Community Planning Committee. She also manages a contract with Parents Lets Unite for Kids (PLUK) to maintain existing parent support groups for families of children with SED and to develop the groups in additional communities and presents at conferences including the MT-NAMI conference and the Montana Behavioral Initiative summer institute sponsored by the Office of Public Instruction.

CMHB's Youth Coordinator (a VISTA volunteer), has developed a Youth Move chapter and offered a Youth Conference concurrent with the Parent Empowerment and Advocacy

Conference this year. She also works with the local Helena YouthMove group and is engaging with other youth support efforts statewide.

A Community Based Alternatives to Psychiatric Residential Treatment Facilities (PRTF) demonstration grant is managed by CMHB. This 1915(c) Home and Community Based Services Medicaid Waiver demonstration project uses wraparound facilitation to plan and implement community-based services and natural supports as an alternative to PRTF placement. CMHB staff are plan managers for the project in Billings and Missoula. Two more plan managers were hired in Helena and Great Falls in October of 2010. A fifth site was added and plan manager hired in June 2011.. In May 2010, CMHB contracted with Vroon Vandenberg Associates to hire one their staff to serve as State Wraparound Coordinator to train and credential High-Fidelity Wraparound facilitators and to develop and certify wraparound coaches. The focus is to develop wraparound capacity first in the sites served by the demonstration project. The demonstration grant is in year three of five. If the demonstration project is successful, CMHB plans to apply for a Medicaid waiver to offer this service statewide as a regular service through Medicaid.

Although a SAMHSA Systems of Care (SOC) grant managed by CMHB ended in September 2010. some aspects have continued, including active parent and youth support groups, families and youth participating in their own care planning, a YouthMove chapter and increased family and provider awareness of what wraparound facilitation can offer and how natural and community supports can strengthen a youth and family's functioning. In Billings, the Yellowstone County Children's Alliance, formally the KMA has continued.

In June 2011, the bureau received a grant from the Mental Health Settlement Trust Fund which will assist in training wraparound facilitators, coaches, and peer-to-peer supports. The grant will help the bureau reach its goal of being able to offer wraparound facilitation to families statewide.

Statewide SOC planning for children's mental health services is guided by two groups with overlapping membership who work together: the Statutory Planning Committee and the Community Planning Committee. Members of both committees are appointed by the Director of DPHHS, who chairs the Statutory Planning Committee.

The SOC Statutory Planning Committee is mandated by state law. Its members are state agency leaders from the Addictive and Mental Disorders Division, Child and Family Services, Development Disabilities Program, Chemical Dependency Program, Office of Public Instruction, Department of Corrections, Youth Justice Council of the Board of Crime Control, Supreme Court Youth Services, Early Childhood Services and the Children's Mental Health Bureau. The Mental Health Ombudsman, Governor's Policy Advisor on Families, a representative from the Crow Nation and the CMHB Family Liaison Officer are also members. A family member or a youth with SED may attend. The Statutory Planning Committee meets monthly.

The SOC Community Planning Committee has representation from: family, youth, advocates, local multiagency teams that address needs of youth with SED, providers, a minimum of three members of the Statutory Planning Committee, Native Americans representing at least the percentage of Native Americans in Montana's population and the CMHB's Family Liaison Officer. Other members represent local government, faith communities, or business owners. The

meetings are open to the public. Membership is over 50% family members and youth. Two parents co-chair the Committee. The Community Planning Committee has met quarterly including at least once a year with the Statutory Planning Committee. Given state general fund shortfalls and the end of grant funding, this group may meet less often, sometimes using web meetings or teleconferences. The input from both SOC Planning Committees has been very valuable to CMHB to inform planning.

The work of CMHB with the SOC Planning Committees is guided by the following values:

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

Montana's SCHIP program, Healthy Montana Kids, also funds some children's mental health services for covered youth with SED via the HMK Basic Mental Health Plan that includes pharmacy, inpatient services, therapeutic group home, and outpatient psychotherapy. The HMK Extended Mental Health Plan includes additional services once limits are met on the Basic Mental Health Plan (for outpatient therapy and therapeutic group home) and also includes therapeutic family care, day treatment, respite care and community-based psychiatric rehabilitative treatment and support (CBPRS). The HMK Basic and Extended Mental Health Plans are managed by HMK program staff in the Health Resources Division.

Comprehensive school and community treatment (CSCT) is managed by a program officer in the Health Resources Division. School districts contract with a licensed mental health center for teams made up of a clinician and an aide to provide school-based therapeutic services for SED youth. A CSCT team can serve eight to twelve youth. CSCT is funded by Medicaid. CSCT teams also can serve non-Medicaid youth by billing private insurance or accepting private payment.

The Early Childhood Services Bureau, housed in the Human and Community Services Division, is encouraging early childhood programs to implement the Pyramid Model to Promote Social and Emotional Competence developed at the Center on the Social and Emotional Foundations for Early Learning (CSEFEL). The bureau offered focused training for providers as well as a general training. Some Head Start and Early Head Start programs now have CSCT or contracted mental health consultation services.

Youth in need of emergency psychiatric hospitalization are usually admitted to Shodair Hospital in Helena or Billings Deaconess Hospital in Billings. St. Patrick's Hospital in Missoula also provides this service.

Youth in need of psychiatric residential treatment are first referred to the three in-state PRTFs: Acadia in Butte, Shodair in Helena, and Yellowstone Boys and Girls Ranch in Billings. In Billings, Missoula, Helena, Great Falls and Kalispell they may be referred to the PRTF Waiver program plan manager. When youth in need of PRTF level of care cannot be served in-state, referrals are made to out of state PRTFs certified by CMS and enrolled as Montana Medicaid providers.

There are four regional mental health centers with satellite offices in multiple communities and seventeen additional licensed mental health centers, some with satellite offices. Many of these mental health centers provide children's mental health services.

Private, licensed mental health professionals, physicians and APRNs also provide public mental health services for youth.

Criterion 1 Comprehensive Community-Based Mental Health Service Systems

Child-Available Services

Health, Mental Health, and Rehabilitation Services

Health

Funding for children's public health services is available through children's Medicaid (HMK+) and CHIP (HMK). Free or sliding scale health services also are available through county Health Departments, community health centers, Indian Health Services facilities on reservations and urban Indian center clinics. DPHHS manages public health services for children through the Developmental Services Division, Children's Mental Health Bureau, and the Public Health and Safety Division. Bureaus within those Divisions that deal with health needs of children include the Maternal and Child Health Bureau and the Early Childhood Services Bureau, among others. Some examples of health services available in addition to medical and dental services covered by Medicaid or CHIP include: WIC, the Medicaid Nurse First Helpline, immunizations, and Early Periodic Screening Diagnosis and Treatment (EPSDT).

Mental Health

The four "community" mental health centers include:

Center for Mental Health, based in Great Falls. The center serves 13 counties in north central Montana. Service area includes Helena, the state capital, as well as rural counties. Services for youth include: youth case management, day treatment, therapeutic group care, CSCT in 15 schools, outpatient therapy, medication management, and crisis intervention. This center also offers DBT groups for adolescents. A telemedicine network is available. The region includes 3 Indian reservations: Blackfeet, Fort Belknap Belknap, and Rocky Boys.

Eastern Montana Community Mental Health Center, based in Miles City. The center serves 17 rural counties in eastern Montana. Services for youth include: outpatient therapy, medication management and crisis intervention. A telemedicine network is available. The region includes two Indian reservations: Fort Peck and Northern Cheyenne.

South Central Regional Mental Health Center, based in Billings. The center provides services in a 12-county region in south-central Montana. Services for youth include: CSCT, therapeutic group care, outpatient therapy, medication management and crisis intervention. This region includes the Crow reservation.

Western Montana Community Mental Health Center, based in Missoula. The center serves 15 counties in western Montana. Services for youth include: youth case management, day treatment, CSCT in 18 schools, therapeutic group care, medication management, outpatient therapy, some additional support services and some chemical dependency services. This region includes the Flathead Reservation.

All of the regional mental health centers have satellite offices in multiple communities in the regions they serve. Several of the additional mental health centers described below also have multiple satellite offices or CSCT service sites, especially A.W.A.R.E., Inc, Youth Dynamics, Inc., Yellowstone Boys and Girls Ranch and Alta Care.

Montana has 12 additional licensed mental health centers that serve youth: **Alta Care/Acadia,** headquartered in Butte, provides CSCT in 98 schools in 48 school districts across the state. It is the largest provider of CSCT. **A.W.A.R.E., Inc.,** headquartered in Anaconda, provides youth case management, day treatment, CSCT in about 13 schools in 6 school districts across the state, therapeutic group care, therapeutic family care, medication management, and outpatient therapy. This agency also provides multiple services for DD children and adults. **Bitterroot Valley Education Cooperative,** headquartered in Stevensville, provides CSCT in 8 schools in 5 school districts. The **Community Crisis Center** in Billings provides outpatient crisis response geared to adults, but can act as a resource for youth crises. **Full Circle Counseling Solutions** in Missoula provides therapeutic family and foster care, outpatient therapy services, some additional support services and CSCT in 7 schools in 1 school district. **Intermountain,** headquartered in Helena, provides therapeutic group care, therapeutic foster and family care, youth case management, day treatment, CSCT in 9 schools in 2 school districts and medication management. Intermountain offers some services in Great Falls and Kalispell. **Montana Community Services** in Billings, provides therapeutic group care. **New Day, Inc.** in Billings provides youth case management, therapeutic group care and day treatment. This agency also provides youth case management services on the Crow reservation and has a focus on providing services to Native American youth. **Northwest Behavioral Health,** headquartered in Kalispell, provides youth partial hospitalization. It also provides CSCT in 9 schools in 2 school districts in the Kalispell area. **Sunburst Mental Health Services,** in Polson, provides youth case management and outpatient therapy services. **Yellowstone Boys and Girls Ranch,** headquartered in Billings, provides youth case management, day treatment, therapeutic group care, therapeutic foster and family care and CSCT in14 schools in 8 school districts. **Youth Dynamics, Inc.**, headquartered in Billings, provides youth case management, day treatment, therapeutic group care and therapeutic foster and family care in several communities.

Private providers (psychiatrists, psychologists, LCSWs, LCPCs, LMFTs, physicians and APRNs) also offer mental health services for Medicaid and CHIP eligible youth. Billings Clinic Behavioral Health psychiatrists assist with provision of psychiatric consultation for youth in eastern Montana. The telemedicine network reduces some of the necessity for families to travel to Billings for their child's medication management.

For children from birth to 3, free screening for developmental disabilities, including autism, is available through the Developmental Disabilities Program. IDEA Part C funds this service. A child with developmental disabilities who is found eligible may also receive services to address the disability.

Rehabilitation Services

Community Based Psychiatric Rehabilitation and Support Services (CBPRS) are available through licensed mental health centers. CBPRS provides support to the youth in addressing

specific goals in the youth's treatment plan. The service requires prior approval by a CMHB Clinical Program Officer.

Employment Services

Youth approaching age 18 may be referred to Vocational Rehabilitation Services for assistance with employment. For youth with IEPs who are 16 and older, a transition plan is required and usually addresses preparation for employment. Supported employment services for adults with DD or SDMI may be available after age 18 if the youth is eligible.

Housing Services

Most youth with SED live with their families. Youth whose needs cannot be managed in their families may be placed in PRTFs or community group homes, but those levels of care are not intended to be permanent placements.

High needs SED youth who also are eligible for services for developmental disabilities may be screened in to a children's DD group home, which is a long term placement. This is dependent on availability of funding for the youth through the DD program, availability of a slot in a children's group home, the priority of the child's need compared to others on the referral list and an assessment of whether the child is a good fit for that group home's current milieu.

Youth who are turning 18 who cannot return to a family home and who are eligible for services from the developmental disabilities program or the adult mental health system are referred to adult case managers in those systems so that access to appropriate housing or supported living services can be sought for them.

The Foster Care Independence Program, through Chaffee funding, offers housing assistance to youth aging out of the foster care system. Public housing is available in many larger communities, but often there is a waiting list.

Great Falls, Missoula, Helena and Billings have homeless shelters for families and youth, but many shelters only accept adults. Some churches provide shelter and food for homeless families.

Educational Services

For students with SED, Comprehensive School and Community Treatment programs in the schools provide mental health support in classrooms, 1:1 behavioral aides, and individual, group and family therapy. There are 191 schools offering CSCT services in 80 school districts across Montana. CSCT is offered in many rural and reservation schools as well as in more populated communities. CSCT is available for all ages - from Early Head Start through high school. Youth do not have to qualify for special education services to receive CSCT. CSCT programs can bill Medicaid, private insurance or offer a private pay sliding fee scale option.

The Montana Behavioral Initiative (MBI), sponsored by the Office of Public Instruction, offers training and supports to schools at all grade levels who choose the become an "MBI school".

MBI promotes a positive school culture of mutual respect, the use of positive behavioral supports with all students and targeted interventions to assist students with more intensive needs. MBI offers a Summer Institute yearly to provide training. Since 2009 the Institute has offered mental health tracks.

The Early Childhood Services Bureau is making training and coaching in supporting the social and emotional development of young children available to providers of early childhood services (such as Headstart, preschools, and daycares). They are using the CSEFEL model.

Substance Abuse and Co-Occurring

The Addictive and Mental Disabilities Division (AMDD) maintains contracts with chemical dependency programs across the state for state-funded chemical dependency services. Children's Mental Health Bureau does not manage any funding for substance abuse services for youth.

There are two providers of inpatient chemical dependency treatment for Medicaid eligible youth, Rimrock in Billings and Teen Recovery in Missoula. Outpatient services are available in several communities, but the providers often have a waiting list.

Although co-occurring disorders are presumed to be common with older youth, most providers of public children's mental health services (PRTFs, group homes, and clinicians) are not trained to provide integrated services for youth with co-occurring disorders. A Co-Occurring Change Agent task force meets regularly and includes a Regional Program Officer from CMHB. Some of the licensed mental health centers that serve youth offer substance abuse services.

Medical and Dental Services

Youth with SED may access medical and dental services if eligible for Medicaid (HMK+) or CHIP (HMK). County Health Departments and Community Health Centers also provide some medical and dental services for low-income residents. Finding a dentist who will accept Medicaid is difficult in some communities. Medicaid recipients can access medical advice through the Nurse First help line.

Support Services

Respite is available through licensed mental health centers. The payment source is state general funds managed by CMHB. When the funds are exhausted, respite becomes unavailable until the start of the next SFY. CMHB is considering an alternative method of managing the respite funds to address this issue and to give families more choice in the way they use respite.

Community Based Psychiatric Rehabilitation and Support Services (CBPRS) are available through licensed mental health centers. See the "Rehabilitation Services" section above for additional details about this service.

Individuals with Disabilities Education Act (IDEA) Services

Many students with SED qualify for special education services and have IEPs that provide for individualized supports to help them participate in their education. For students 16 and older, the IEP must include plans to assist the youth with transition from school to adulthood. Frequently the transition plans include referral to vocational rehabilitation services, employment services, adult mental health services or other post secondary education and training programs.

The Office of Public Instruction monitors compliance of Montana schools with the requirements of IDEA.

Targeted Youth Case Management Services

Targeted youth case management is available to Medicaid-eligible youth with SED through licensed mental health centers. Parent and youth participation in care planning is an essential component. A CMHB Clinical Program Officer provides oversight for this service.

CMHB will provide training for youth case managers and their supervisors to individualize and improve crisis planning, increasing the families' and the communities' capacity to stabilize youth in mental health crises.

Activities to Reduce Hospitalization

Provision of High-Fidelity Wraparound training twice yearly in PRTF Waiver demonstration project sites (Billings, Missoula, Helena, Great Falls and Kalispell) and wraparound coach development will strengthen family and youth voice in service and crisis planning and will strengthen the plans through the inclusion of additional family and community supports. The Waiver is designed to be used for youth who meet treatment criteria for a PRTF and provides community-based services in lieu of residential treatment utilizing the High Fidelity Wraparound process.

CMHB is discussing the possibility of developing a short term "stabilization" option with in-state PRTFs. This could be a very useful option for youth served by the demonstration project and for other youth as needed.

Provision of training to targeted youth case managers to improve crisis planning for SED youth may increase family and community capacity to stabilize youth crises. The CMHB Clinical Program Officer who oversees youth case management services is developing a monthly web-based training for youth case managers. Improving crisis planning will be a training topic.

Therapeutic foster care and therapeutic family care services provided through mental health centers strengthen supports for high needs youth and their families and can help them manage most crises.

Regional Program Officers (RPOs) work diligently with youth case managers, Magellan Regional Care Coordinators other state agency staff, providers and families to strengthen

community and family capacity to care for high needs youth in their family and community and to manage crises without hospitalization or placement into PRTFs.

Criterion 2 Mental Health System Data Epidemiology

<u>Child-Estimate of Prevalence</u>

According to information provided by the National Association of State Mental Health Program Directors Research Institute's State Data Infrastructure Coordinating Center (NRI/SDICC) for CMHS, for 2009 the population of children in Montana aged 9 to 17 was 110,424. The percentage of Montana children aged 9 to 17 with SED was estimated to be between 10 and 12%. The number of children in Montana with SED was estimated to be 12,147. These estimates include children with Level of Functioning Scores of up to 60.

Montana's definition of Serious Emotional Disturbance is:

<u>SED Definition</u>:

FOR CHILDREN AGE 6 – 17

Must meet *one* of the following within the last 12 months as diagnosed by licensed mental health professional (must be moderate/severe):			
i.	Childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90)	**xi.**	Dysthymic disorder (300.4)
ii.	Oppositional defiant disorder (313.81)	**xii.**	Cyclothymic disorder (301.13)
iii.	Autistic disorder (299.00)	**xiii.**	Generalized anxiety disorder (300.02)
iv.	Pervasive development disorder NOS (299.80)	**xiv.**	Posttraumatic stress disorder (chronic) (309.81)
v.	Asperger's disorder (299.80)	**xv.**	Dissociative identity disorder (300.14)
vi.	Separation anxiety disorder (309.21)	**xvi.**	Sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89)
vii.	Reactive attachment disorder of infancy or early childhood (313.89)	**xvii.**	Anorexia nervosa (severe) (307.1)
viii.	Schizoaffective disorder (295.70)	**xviii.**	Bulimia nervosa (severe) (307.51)
ix.	Mood disorder (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89)	**xix.**	Intermittent explosive disorder (312.34)
x.	Obsessive-compulsive disorder	**xx.**	Attention

		(300.3)				deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above

AND (Must meet *one* of the following):			
		As a result of the diagnosis determined above, must consistently and persistently demonstrate behavioral abnormality in *two or more* of the following for a period of at least *six months* that cannot be attributed to intellectual, sensory or health factors:	
		i.	Has failed to establish or maintain developmental and culturally appropriate relationships with adult caregivers or authority figures
		ii.	Has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships
		iii.	Has failed to demonstrate a developmentally appropriate range and expression of emotion or mood
		iv.	Has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation setting
		v.	Has displayed behavior that is seriously detrimental to the youth's growth development, safety or welfare, or to the safety or welfare of others
		vi.	Has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment

FOR CHILDREN AGE 0 – 5

Must exhibit *one or more* of the following for at least *six months* (or is predicted to continue for at least 6 months) which cannot be attributed to intellectual, sensory or health factors and results in substantial impairment in functioning:		
	i.	Atypical, disruptive or dangerous behavior which is aggressive or self-injurious
	ii.	Atypical emotional response which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations
	iii.	Atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual
	iv.	Lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction
	v.	Indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child
	vi.	Inappropriate and extreme fearfulness or other distress which does not respond to comfort by caregivers

Criterion 3 Children's Services

Comprehensive School and Community Treatment (CSCT) is currently being offered in about 191 schools. Nine mental health centers provide the CSCT teams for the schools.

The Great Falls Early Childhood Coalition and Great Falls Public Schools opened the Early Learning Family (ELF) Center in Great Falls in January 2010. Their goal is to create a seamless service system in one Great Falls location that is "all inclusive" in meeting the needs of their community's children ages birth to six. Their mission is "Collaborating to integrate the wide range of services of multiple agencies and providers in order to leverage the best possible delivery of services to children ages birth to six." An RPO participates in the Early Childhood Coalition and helped develop the Center.

The Montana Behavioral Initiative (MBI) Summer Institute, sponsored by the state Office of Public Instruction (OPI) provides training to teachers and other school staff. A mental health track was offered for the first time in 2009 and has continued each year since. A parent involvement track was added in 2010. The Summer Institute now includes a youth and parent panel and digital stories by youth with SED. A session on the NAMI Basics for Providers training was presented by its developers from Kalispell. The state president of the PTA offered to put an announcement in their newsletter about the upcoming Train the Teachers class for NAMI Basics. An RPO participates in the planning committee for each year's Summer Institute. The CMHB Family Liaison Officer put together and participated in the parent and youth panel. The digital stories were done by Helena youth.

CMHB contracted with PLUK to develop support groups for parents of SED youth. Support groups now meet in Billings, Missoula, Helena and Great Falls.

The PRTF Waiver demonstration project is now offering a community-based alternative to PRTF placement in Billings, Missoula, Great Falls, Helena and Kalispell. Three sites were added in the last year.

The PRTF Waiver Demonstration project uses the wraparound process to develop integrated, community-based plans to serve high-needs youth. The number of youth served is growing in all sites. The state is using settlement monies to continue its work with Vroon Vandenberg to train facilitators and has hired two Statewide Wraparound Coordinators to train facilitators and provide coaching for them.

The Regional Program Officers use their effective working relationships with local state agency staff and providers to influence the development of integrated, community-based services plans for high needs youth. The RPOs use flexible funds (if the youth is eligible) to fill in gaps in the service plans and to share costs. Recent examples include: purchasing a computer to help a child with learning difficulties remain in the classroom with the school purchasing software; paying for wraparound facilitation for a child not eligible for the waiver.

The RPO liaison with the DDP maintains a list of youth with SED who also may need services for developmental disabilities. The list indicates whether eligibility for DD services has been

determined. If eligibility is not yet determined, that effort is made if the parent agrees. For youth age 16 or older, the list indicates whether there is a plan for adult services in either the DD or adult mental health system and describes the plan. Younger children on the list may be identified as needing children's DD services or a more integrated service plan. This list is used by CMHB, DDP, and CFSD.

The Interagency Transition Workgroup continues to meet monthly. In May 2010 the group developed a Transition Flow Chart for use by child-serving agency staff. The group provides consultation on difficult transition situations referred by state agency staff. It also makes recommendations to address systemic barriers in transition to adult mental health or DD services. CMHB staff including the RPO liaison with DDP participate in this group.

The Office of Public Instruction and CMHB contracted for a person to do research and develop a White Paper on best practices in school mental health to inform planning. The paper produced a number of recommendations that will be used in planning.

The Early Childhood Services Bureau started a "Best Beginnings" DPHHS Workgroup in spring 2010 to bring together representatives from each state agency that serves young children and their families to develop a public interface for all services to young children that will be easier for consumers to use - a "no wrong door" approach. Some cross-training has already occurred. The CMHB Community Services Supervisor participates in this group. Other participants include: Maternal and Child Health, Healthy Montana Kids (CHIP), Headstart, the Office of Public Assistance and others.

PRTFs are now required to submit a Discharge Plan Review form to accompany continued stay requests in order to assist the Bureau staff to ensure appropriate discharge planning is occurring. This also assists CFSD to improve their access to information about youth they serve who are in PRTFs.

The CMHB Youth Coordinator helped develop Montana's first Youth Move chapter. She is working to develop a statewide youth network.

Criterion 4 Targeted Services to Rural and Homeless Populations

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

CSCT programs also are providing access to mental health services to young children in some elementary schools, Head Start and Early Head Start Programs. In Great Falls CSCT is available in Title IX and IDEA preschool classrooms.

The RPO for the north-central region participates in Homeless Coalition meetings in Great Falls.

Criterion 5 Management Systems

CMHB is continuing its work with Vroon Vandenberg and Associates to provide training and professional development in High Fidelity Wraparound facilitation.

CMHB continues to meet with providers and provider groups (such as the Montana Children's Initiative and the in-state PRTFs) to address issues and concerns and to discuss strategies to improve practice and processes. PRTF providers participated in the development of the Discharge Plan Review Form now required with PRTF continued stay requests.

Step 2: Identify the Unmet Service Needs and Critical Gaps Within the Current System

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Step 2. Identify the unmet service needs and critical gaps within the current system.

Montana has not developed a formal needs assessment process for mental health services. Addictive and Mental Disorders Division (AMDD) will be collaborating with our Chemical Dependency Division for the Block Grant needs assessment process for the next Block Grant cycle.

AMDD has used local and regional partners to identify the needs and gaps of the mental health population relevant to the Community Mental Health Services Block Grant for several years. (Partners and roles are described under Involvement of Individuals and Families).

A very small (8 question) survey was implemented to the ten (10) licensed Mental Health Centers (children and adult), Tribal Agencies, and Local Advisory Councils (LAC)s for consumer input, through SurveyMonkey, a web-based survey tool that provides easy access, easy to analyze, and easy to display information. The purpose of the survey was to substantiate information AMDD has received from providers and consumer groups and to also support our decision on use of Community Mental Health Block Grant dollars for our state Priorities – 1. Support un-underinsured adults with severe and disabling mental illness to receive prescriber services of their choice; and 2. Begin to promote and implement evidence-based employment programs.

Of the ten (10) Mental Health Centers licensed in the state, seven (7) responded to the survey – 70% response rate.

Mental Health Center Responses relative to Priorities:

Q – Mental Health Services Provided.

Mental Health Treatment	100%	
Substance Abuse Treatment	71.4%	
Co-Occurring Capable Treatment	85.7%	
Supported Employment		85.7%

Q – Unmet Needs or Service Needs

Prescribers/Medication Management	42.9%	
Supported Employment Opportunities		28.6%
Competitive Community Employment Opportunities		57.1%

Q – Waiting List for Mental Health Services Plan (MHSP)

Yes	71.4%
No	28.6%

A total of nineteen (19) surveys were sent to Tribal Health Directors, Urban Clinic Directors and other Medicaid providers. Of the 19 surveys sent, three (3) responded to the survey in full –15% response rate.

Tribal and Urban Indian Mental Health Centers Responses Relative to Priorities: (6 responses – 3 completed):

Q – Mental Health Services Provided.

Mental Health Treatment	83.3%	
Substance Abuse Treatment	83.3%	
Co-Occurring Capable Treatment	83.3%	
Supported Employment		16.7%

Q – Unmet Needs or Service Needs

Prescribers/Medication Management	50.0%	
Supported Employment Opportunities		25.0%
Competitive Community Employment Opportunities		50.0%

Local Advisory Council Responses: (Individual members were asked to complete) (33 Responded, 28 Completed – 84.8%):

Q – Services Have Access To:

Mental Health Treatment	87.9%	
Substance Abuse Treatment	57.6%	
Co-Occurring Capable Treatment	57.6%	
Supported Employment		18.2%

Q – Unmet Needs or Service Needs

Prescribers/Medication Management	71.0%	
Supported Employment Opportunities		48.4%
Competitive Community Employment Opportunities		48.4%

Step 3 – Table 2: Prioritize State Planning Activities

1. Mental Health/Recovery Services for Individuals with Severe Disabling Mental Illness who are Uninsured or Underinsured.
2. Development of Community Support (Rehabilitative) Evidence Based Services.

Priority 1

Objective 1: Provide diagnostic and medication management services and necessary follow up services for individuals with severe disabling mental illness who are uninsured or underinsured at or below 150% of poverty.

Strategy: Provide an approved listing of psychotropic medications through the plan.
Strategy: Services are paid for through fee-for-service payment scheduled.
Strategy: Providers will have complied with Montana Mental Services Plan requirements as part of Montana's Healthcare Program enrollment.
Strategy: Provide supported laboratory services necessary to treat.

Performance Indicator: Eligible individuals will access MHSP Services.
Performance Indicator: Programs will meet program fidelity.
Performance Indicator: Develop a statewide network of providers.

Priority 2

Objective 1: Development of quality community mental health services that support recovery and community integration through employment.

Strategy: Promote use of Evidence Based Practices by including Individual Placement and Support (IPS)/Supported Employment Services as part of Comprehensive Continuum of Care.

Performance Indicator: Mental Health Centers/Agencies develop or incorporate evidence based practices into employment programs.
Performance Indicator: Establish baseline for number of individuals working in competitive community employment opportunities.

Objective 2: Promote Program Fidelity/Standards

Strategy: Provide training and support to mental health centers/agencies on evidence based employment practices.

Performance Indicator: Mental Health Centers providing employment programs will progress to evidence based employment model.
Performance Indicator: Participating programs will meet fidelity of the IPS/Supported Employment model.

III. USE OF BLOCK GRANT DOLLARS FOR BLOCK GRANT ACTIVITIES

Table 4: Services Purchased Using Reimbursement Strategy

Priority 1 services will be reimbursed through fee-for-service. See Fee Schedule link under Footnotes.

Services Purchased - CPT Codes:

90801-09815 - Psychiatric Interviews and Appointments
99211-99215 - Office/Outpatient visits
99281-99285 - Emergency Visits

Priority 2 - Employment Services will be purchased through a Request for Proposal (RFP) and contract for services strategy. Providers will respond to the RFP, a committee will review and score under administrative rules, and projects will be chosen based on the proposal responses - meet standards.

AMDD will be providing technical assistance and support to providers to progress to evidence based supported employment practices. Individual Placement and Support (IPS) program will be used to monitor and determine measure of fidelity.

IV: NARRATIVE PLAN

D. Activities that Support Individuals in Directing the Services

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:
Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
What services for individuals and their support systems are self-directed?
What participant-directed options do you have in your State?
What percentage of individuals funded through the SMHA or SSA self direct their care?
What supports does your State offer to assist individuals to self direct their care

D. Activities that Support Individuals in Directing the Services - Response

Montana provides definition for Community-based psychiatric rehabilitation and support; and, "Recovery-oriented" services in Administrative Rule – Mental Health Center Services for adults, Definitions (37.88.901).

"Community-based psychiatric rehabilitation and support" means services provided in home, school, workplace, and community settings for adults with severe disabling mental illness. Services are provided by trained mental health personnel under the direction of and according to individualized treatment plans. The services may be provided outside of normal clinical or mental health program settings and are designed to assist individuals in developing the skills and behaviors necessary for recovery. Community-based psychiatric rehabilitation and support services are provided on a face-to-face basis with the individuals, family members, teachers, employers or other key individuals in the individual's life when such contacts are clearly necessary to meet goals established in the individualized strength-based treatment plan.
(a) Community-based psychiatric rehabilitation and support includes but is not limited to the following services:
(i) evaluation and assessment of symptomatic, behavioral, social and environmental barriers to independent living and community integration;
(ii) assisting the individual to develop communication skills, self-management of psychiatric symptoms, and the social networks necessary to minimize social isolation and increase opportunities for a socially integrated life;
(iii) assisting the individual to develop daily living skills and behaviors necessary for maintenance of a home, family relationships and responsibilities, an appropriate education, employment or vocational situation, and productive leisure and social activities;
(iv) immediate intervention in a crisis situation and referral to necessary and appropriate care and treatment.
(b) Community-based psychiatric rehabilitation and support does not include the following:
(i) interventions provided in day treatment or partial hospitalization programs;
(ii) interventions provided in a hospital, nursing home, or residential treatment facility;
(iii) interventions provided by staff of crisis facilities, group homes, or adult foster care providers in such facilities, homes, or settings;
(iv) case planning activities, including but not limited to attending meetings, completing paperwork and other documentation requirements, traveling to and from the individual's home;
(v) therapeutic interventions by licensed practitioners, regardless of the location of the service; and
(vi) activities which are purely recreational in nature.

"**Recovery**" means a process that enables an individual to live a meaningful life in the community. The fundamental components of recovery include self-direction, person-centered strength-based treatment, empowerment, respect, responsibility, and hope.

"**Recovery-oriented mental health services**" means:
(a) respect for and appreciation of the individual that ensures inclusion and participation in all aspects of his or her life;
(b) individualized and person-centered treatment, based on the individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including trauma), and cultural background; and
(c) empowerment of the individual to choose from a range of options and to participate in decisions and to receive education and support in so doing, and to promote personal responsibility for his or her own recovery

What services for individuals and their support systems are self-directed? All services supported by Addictive and Mental Disorders Division as indicated in Administrative Rule.

What participant-directed options do you have in your State? Montana does not have a "Money Follows the Person" for mental health services at this time.

What percentage of individuals funded through the SMHA or SSA self direct their care? All mental health centers implement 'strength-based' case management services; this includes option for individuals to direct the treatment planning process.

What supports does your State offer to assist individuals to self direct their care?
Montana has two statutorily mandated mental health advocates: the Mental Health Ombudsman and the Mental Disability Board of Visitors. Both of these positions are appointed by the Governor and are considered independent. The Board of Visitors was established to ensure that the treatment provided in Montana's public health system for people with developmental disabilities and people with mental illnesses is humane, is consistent with established clinical and other professional standards, and meets the standards set by state law. The Mental Health Ombudsman's role is to represent the interests of consumers of services with the contractor or the Department of Public Health and Human Services and to work directly with consumers to assist them in accessing services and in resolving problems in obtaining services. The Mental Health Services Bureau (MHSB) serves as a resource to the Board of Visitors as well as the Mental Health Ombudsman.

E. Data and Information Technology

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity.
States should respond to the following:
List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
Provider characteristics
Client enrollment, demographics, and characteristics
Admission, assessment, and discharge
Services provided, including type, amount, and individual service provider
Prescription drug utilization
As applicable, for each of these systems, please answer the following:
For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
As applicable, please answer the following:
Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?

Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?
In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

D. <u>Data and Information Technology – Response</u>

IT Systems

The main IT system maintained and/or utilized by Montana is the Medicaid Management Information System (MMIS). For Medicaid purposes, the mechanized claims processing and information retrieval system which states are required to have, unless this requirement is waived by the Secretary, is the MMIS.

The MMIS is an integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" is identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to recipients, providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control. Contractual services may be utilized to perform work for the design, development, installation, or enhancement of a mechanized claims processing and information retrieval system. A fiscal agent who is a private contractor to the state, normally selected through a competitive procurement process, may operate the state's MMIS. A state MMIS fiscal agent contract status report is prepared quarterly from CMS central office following the input from regional offices and is available to download in PDF in the "Downloads" section below. The report is usually prepared within 30 days after the close of a quarter and infrequently when there is a demand due to several state contractor revisions. The report data includes the name of the state fiscal agent contractor, the contract term with option extension period, and regional office contact person with phone and fax number.

QueryPath is an ad-hoc reporting tool, providing users with timely and accurate information for reporting and analysis. Users can access information about claims, recipients, managed care enrollment providers and reference information from the MMIS. The reference information includes drug, procedure code, diagnosis code, RBRVS, DRG and APC data. Users can construct complex queries and analyze the data in an easy point-and-click fashion.
QueryPath is an Internet based application, accessed through Internet Explorer.
The main source of the data in the database is the MMIS (Medicaid Management Information System). Drug related data for the drug and drug rate paths comes from PDCS (Prescription Drug Claims System) X2. A small amount of recipient data comes from the state's eligibility system, CHIMES (Combined Healthcare Information and Eligibility System).

The MMIS runs an adjudication cycle every Monday and Wednesday and a payment cycle every Wednesday. The extract programs for the database run every Wednesday after the adjudication/payment cycle and the data gets loaded into the database every Thursday night.

Most data that is extracted is a straight move from the MMIS file to the database file. The mapping document indicates the source of the data or whether the data is derived. For the derived fields, a business rule explains how the data gets from the source to the database file.

MHS - Mental Health Services System Components

Client Information

Mental Health Services (MHS) System basic client descriptive and demographic information is stored in the Client Master Table (MHSP_CLIENT). This information is obtained from other HHS databases and from recipient information contained in the ACS Decision Support System (DSS). This data is obtained through the use of a stored procedure that is called for each MHS client by a PLSQL package connected to the ACS Oracle server through a DB-Link. This package, along with similar packages connecting to other databases, is executed in a scheduled batch job that runs early each Thursday morning. Virtually all MHS Client Master Table information is received from external sources, without the need for data entry by Mental Health Services Bureau (MHSB) staff.

Primary access to this client information is furnished through the Client Information module. Implemented as a web services form, which displays and allows for editing of client data fields, this application is generally the starting point for staff members needing to look up information on a client. The main static screen which displays name, address, race, date of birth, sex, diagnosis, eligibility types, etc., has beneath it a row of tabs which allow the user to pop up dynamic pages showing current services, MHSP eligibility detail, and pharmacy information.

Client Services Master Table

This component is used as the primary controlling entity for services authorization and tracking. Paid claims data from the ACS Decision Support System is used to update the Mental Health Services Master Table (MHSP_CLIENT_SERV_MSTR) on a weekly basis through a DB-Link to the ACS Oracle server. This local table is then used for validating client services processed by several MHS components, and is modeled after the recipient data interface that provides client descriptive information discussed above. This direct access link is also used to obtain other reference information in addition to just claims data, such as the Procedure Code Reference Table (MHSP_PROC_CODE). Services information is available as a tab page in the Client Information screen, Recovery Markers, the Presumptive Eligibility screen and the Performance Information Screen.

Performance Table

Originally placed into operation in 2004, the Performance Table is a major source of client level Mental Health data needed to meet Federal reporting requirements. Data is currently being provided by Western Montana CMHC, South Central CMHC, the Center for Mental Health, and Eastern Montana CMHC at quarterly intervals (Medicaid and Mental Health Services Plan (MHSP). The Performance Table, a component of the Montana Health and Human Services Oracle database, tracks data on 79 performance variables used in reporting Montana Mental Health Services progress to Federal funding agencies through the URS Tables and State Profiling System. Data is uploaded by providers through an Internet Web page and then posted to an intermediate Staging Table. An Oracle update package (MHSP_UPD_PERF) then reads current

Staging Table (MHSP_PERF_STAGE) entries and posts changes to the Performance Table (MHSP_PERFORM), after writing a snapshot record of the prior information to the Performance History Table (MHSP_PERF_HST). All data uploads are handled through the web, using hypertext transfer protocol (HTTP) without the need for FTP (file transfer protocol). Performance history records generated during the posting process provide a source of change data for use in measuring client progress. Among the 79 data fields collected are measures on whether clients are screened for co-occurring substance use disorders, living arrangements, changes in level of functioning, educational or employment pursuits, whether there are chronic medical problems, and recent arrests. The datasets are submitted to the SMHA via a secure web link and utilized for yearly URS tables sent to the NASMHPD Research Institute. Using client identifiers we are able to identify those clients enrolled in MHSP services.

Recovery Markers

The Recovery Markers application was developed in 2005 to accept client recovery data from service providers for clients receiving targeted case management. The recovery marker data uses several measures to indicate whether there is progress in recovery as a result of treatment. The measures currently in use are housing, employment (including education), level of symptom interference, alcohol and/or drug stages of change and level of substance use. This web application, originally written as Java Server Page (JSP) module, using Struts, a java application framework, was re-written in JavaScript and Java, using an Ajax framework named AjaxTop. The web application has a limited ability to produce reports at the clinician, agency, and state level. Recovery data are required of all case managers each quarter.

Criminal Justice Interface

Active since November of 2005, the Criminal Justice Information System (CJIS) arrest data interface runs as a weekly batch job without manual intervention, providing a fresh table of arrest records to work with each Monday morning. This interface is implemented as an Oracle DB-link from CJIS to the Mental Health Services (MHS) System, using an Oracle stored procedure. This procedure takes records found in the MHSP_CJIS_REQUEST table, looks up records for each client using the social security number, then writes matched records out to the MHSP_CJIS_ARREST table. This project was implemented as a result of a Data-Sharing agreement between AMDD and the Department of Justice, signed in June of 2005. As of June, 2006 the Performance Table, discussed earlier, is automatically updated with information from the CJIS.

ACS Recipient Data Link

An Oracle DB-Link has been in use to connect directly to ACS's Decision Support System since September of 2004. This interface takes advantage of the fact that ACS shares the State internal IP network, where both reside behind a common firewall. The initial link made use of a stored procedure resident on the ACS system. This stored procedure was so successful that a request was later made to extend access to paid claims data for use in validating client services for several additional MHS components. This access link was an important element in accomplishing objectives stated in the 2005 Data Infrastructure Grant for obtaining follow-up information on client treatment progress. By March, 2006, the Mental Health Services System had full access to all Oracle paid claims views through the DB-Link, providing information through both PL/SQL and java-based procedures on a real-time basis. A series of Oracle

packages have been developed that use this link on a weekly basis to automatically update the Client table, the Master Services table, and the Pharmacy table during after hours.

72-Hour Presumptive Eligibility

The goal of the 72-Hour Crisis Stabilization and Psychiatric Support Services initiative is to provide eligibility and payment for crisis management in community settings, including hospitals, for non-Medicaid eligible clients. This application registers clients with Mental Health emergencies for special services to be made available by authorized providers during a three day period. The eligibility component of this program was handled under the DIG grant and implemented as an additional Oracle table as a part of TESS. A special web application was developed to allow MHSB staff to enter client identifying information and eligibility span dates into the database. This information is extracted as part of the nightly TESS_TEAMS_EXTRACT run and passed on to ACS as described earlier. After several months of problems with interactions of 72-Hour records with MHSP eligibility records, implementation of this component was finally completed in April, 2009.

List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following: (See Above)

- Provider characteristics – Information can be gleaned from licensure process through the Quality Assurance Division.
- Client enrollment, demographics, and characteristics – MMIS and QP
- Admission, assessment, and discharge – MMIS and QP
- Services provided, including type, amount, and individual service provider – MMIS and QP
- Prescription drug utilization – Prescription Drug Claim System (PDCS) and MMIS and QP

As applicable, for each of these systems, please answer the following:

- For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers? - Yes
- Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider? Not that we are aware.
- Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client? - Yes
- Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider? - Yes
- Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)? – Yes

As applicable, please answer the following:

- Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information? - Yes

- Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports? – It can.
- Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues? – Yes, beginning stages
- Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data? Yes, statewide health information exchange is under the supervision of the Auditor's Office – Insurance Division. The Commissioner has the responsibility of implementing the new insurance reforms in Montana. Participation may occur at the Director's level.
- Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards? Montana has an RFP out for a new MMIS. Three companies have bid and demonstrated their system. The Department has not yet announced if an award or contract has been made.

F. Quality Improvement Reporting

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan

F. Quality Improvement Reporting - Response

AMDD has CQI process for specific programs, i.e. Medicaid Waiver, PACT Program. In addition, AMDD has a Quality Assurance Division to provide direct oversight of mental health center licensing and standards.

The Department of Public Health and Human Services (DPHHS) Quality Assurance Division fulfills the following role:

- Licensing and/or certifying health care, child care, and residential services;
- Detecting and investigating abuse and fraud committed by recipients of Temporary Assistance to Needy Families (TANF), Medicaid and Food Stamp programs;
- Monitoring recipient overpayment claims for TANF, Medicaid and SNAP;
- Performing federally mandated quality-control reviews of the Medicaid and Food Stamp programs;
- Reducing Medicaid costs by identifying other insurers or parties responsible for paying a beneficiary's medical expenses;
- Providing internal and independent audits for DPHHS programs;
- Conducting retrospective reviews of Medicaid provider claims;
- Determining medical necessity for prior authorization of medical services and requests for durable medical equipment;
- Providing independent fair hearings for clients and providers participating in DPHHS programs;
- Monitoring and evaluating Health Maintenance Organizations for quality assurance and network adequacy;
- Maintaining a certified nurse aide registry;
- Approving and monitoring nurse aide training programs;
- Operating the Certificate of Need program; and
- Ensuring department compliance with the federal Health Information Portability and Accountability Act (HIPAA)

AMDD does not have a formal CQI process for programs funded under the Mental Health Block Grant at this time; technical assistance in the area by SAMHSA would be welcome.

G. Consultation With Tribes

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.
Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

G. Consultation With Tribes - Response

An invitation for formal consultation on the Mental Health Block Grant and Substance Abuse, Prevention, and Treatment Block Grant was sent to all tribal council chairs on June 30, 2011. A copy of the invitation is included.

Tribal Chairs and Other Interest Parties Invited:

CHAIRMAN	TRIBE
Chairman Al Stafne	FT PECK TRIBES
Chairman Cedric Black Eagle	CROW TRIBE
President Tracy King	FT. BELKNAP INDIAN COMMUNITY
Chairman Bruce Sunchild	CHIPPEWA CREE TRIBE
President Leroy Spang	N. CHEYENNE TRIBE
Chairman ET Bud Moran	CONFEDERATED SALISH AND KOOTENAI TRIBES
Chairman Willie Sharp Jr.	BLACKFEET TRIBE

Name	Title	Organization
Ernestine Belcourt	Executive Director	Indian Family Health Clinic
June Tatsey	Director	Blackfeet Tribal Health Department
Kim Azure	Director	Confederated Salish & Kootenai Behavioral Health Program
Marjorie Bear Don't Walk	Executive Director	Indian Health Board of Billings
Patrick Calf Looking	Director	Crystal Creek Treatment Center
David Roundstone	Director	Northern Cheyenne Board of Health
Fawn Tadios	CEO	Rocky Boy's Health Board
Keith Bailey	Director	Helena Indian Alliance
LeeAnn Johnson	Director	Crow Tribal Health Department
Linda Kinsey	Director	Fort Belknap CDC
Moke Eaglefeathers	Executive Director	North American Indian Alliance
Pete Conway	Director	Indian Health Service
Velva Doore	Director	Fort Belknap Tribal Health Department
Delphine LeMay	Director	Spotted Bull Treatment Center
Gary James Melbourne	Director	Fort Peck Tribal Health Project
Kevin Howlett	Department Head	CS&K Tribal Health and Human Services
Lenore Meyers	Director	White Sky Hope Treatment Center
Lucille Other Medicine	Director	Crow Nation Wellness Center
Patrick Weaselhead	Director	Missoula Indian Center (Urban clinic)
Terry Beartusk	Director	Northern Cheyenne Recovery

August 3 Meeting Participants:

Name	Title	Organization	Affiliation
Anna Whiting Sorrell	Director	DPHHS	State of Montana
Joan Cassidy	Chemical Dependency Bureau Chief	DPHHS/AMDD	State of Montana
Pat E. Calf looking	Director	Crystal Creek Lodge Treatment Center	Blackfeet
Penny Anderson	Medicaid Resource Director	CSKT Tribal Health and Human Services	CSKT
Kevin Howlett	Department Head	CSKT Tribal Health and Human Services	CSKT
Debra Hayton, LCSW		Helena Indian Alliance	
Marcy Lay, LAC	LAC	Helena Indian Alliance	
Ori Medicinebull		Northern Cheyenne Recovery Center	NCRC
William A. Martin		North American Indian Alliance	
Patsy Kirkhart		Indian Family Health Clinic	
Mary DeBerry		Indian Family Health Clinic	
Lenore Myers	Director	White Sky Hope Center	Rocky Boy's
Rod Robinson		Spotted Bull Treatment Center	Fort Peck Tribes
Tom Camel	Board Member	MHOAC	CSKT
Glenda Oldenburg	Mental Health Bureau Chief	DPHHS/AMDD	State of Montana
Marlene D-Ross	Planning Officer	DPHHS/AMDD	State of Montana
Lou Thompson	Administrator	DPHHS/AMDD	State of Montana
Shannon Real Bird	Business Manager	Crow Health and Human Services	Crow
Frank Clinch	Deputy Chief Legal Counsel	DPHHS/OLA	State of Montana
Ian McEwen	Tribal Medicaid Specialist	DPHHS	State of Montana
Geraldine Taylor	Office Manager	DPHHS/AMDD	State of Montana

The Director of the Department of Public Health and Human Services (DPHHS), Anna Whiting Sorrell, opened the meeting with a welcome and introductions. The Director served as the facilitator and official representative for DPHHS.

Agenda Items:

- Formal Request for Consultation – Anna Whiting Sorrell
- History of Substance Abuse & Mental Health Block Grant – Lou Thompson, Administrator, Addictive and Mental Disorders Division
- Overview of Substance Abuse prevention and Treatment Block Grant (SAPTBG), Joan Cassidy, Chemical Dependency Services Bureau Chief
- Invitation for Comments on SAPT Block Grant
- Overview of Community Mental Health Services Block Grant (MHSBG), Glenda Oldenburg, Mental Health Services Bureau Chief
- Invitation for Comments on MHS Block Grant

Written Comments were accepted through August 17, 2011. Comments were submitted to the Tribal Medicaid Specialist in the Director's Office.

Final, approved transcriptions of the meeting and comments have not been released. As soon as more information is available it will be forwarded to Montana's Project Officers.

H. Service Management Strategies

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

H. Service Management Strategies- Response

AMDD will need to review current standards of care for the services purchased under the Mental Health Block Grant. AMDD will be working with our utilization management contractor to identity over-underutilization trends and appropriate utilization of services.

I. State Dashboards (Table 10)

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.
In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

I. State Dashboards (Table 10)- Response

Montana will discuss this process with the State Project Officer after submission of Community Mental Health Block Grant.

J. Suicide Prevention

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America?s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Suicide Prevention Plan attached from website:

http://www.dphhs.mt.gov/amdd/statesuicideplan.pdf

K. Technical Assistance Needs

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

K. Technical Assistance Needs- Response

Montana would like to be considered for technical needs in the areas of Service Management and Quality Improvement Process.

L. Involvement of Individuals and Families

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

•How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
•Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
•Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
•How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
• How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

L. Involvement of Individuals and Families - Response

State-level involvement of individuals and families begins with the Mental Health Oversight and Advisory Council in Montana. The Montana Mental Health Oversight Advisory Council's mission is to serve as "*Partners in planning for recovery based mental health system throughout Montana*."

The Council's vision is: *a collaborative public mental health system that promotes independence, self-determination and recovery through individual, family, advocate and community participation. With effective treatment, knowledge and support, Montanans with mental disorders will achieve education, meaningful work, satisfying family relationships, friendships and participation in the community*.

The purpose of the Council is also defined in Montana state law (53-21-701(6).

The Mental Health Oversight Advisory Committee has established the following guiding principles:

- Recovery and resilience
- Equity, access and satisfaction
- Cultural competence
- Community-based solutions
- Community education and awareness
- Flexibility
- Criminal Justice diversion
- Address co-occurring disorders
- Fiscal responsibility

The Council's by-laws require '***a majority of members shall be consumers of mental health services..'*** to ensure clear consumer representation and leadership. The Council as been reduced to two (2) meetings each fiscal year because of budget concerns. The Council made the decision to meet fewer times in the fiscal year in lieu of decreasing membership to impact cost of operating. To ensure Council business continues, the Council uses teleconferences and/or videoconferencing, depending on cost, to hold committee meetings more often for planning and advocacy.

Montana State Statute, *53-21-702, Mental health care system – eligibility – services – advisory council*, provides the framework for the state public mental health system. The community framework **begins at the local level with local advisory councils** that "*report to and meet on a regular basis with the advisory council* (Mental Health Oversight and Advisory Council).

Local Advisory Councils are a coalition of community members interested in planning, evaluating and strengthening their **local** community mental health services. LACs are an integral element to a successful system of public mental health care. *Change begins at the local level.* It is expected that LACs consist of a broad group of stakeholders that represent the community. It is encouraged that stakeholder groups include: Consumer/family members; government and law enforcement officials; mental health service providers, mental health advocates; public health

and medical providers, and citizenry that represent the local/regional culture. Each LAC is recognized through representation on the Service Area Authority Board. LACs are the foundation for recommendations to the SAA, DPHHS, MHOAC, on program issues affecting local communities. The Mental Health Services Bureau, through the Community Resources and Support Program developed a Local Advisory Council Handbook to provide guidance and support to new and established members.

Local Advisory Councils (LACs) provide input to the Mental Health Oversight Advisory Council (MHOAC) through the regional Service Area Authorities (SAA) representative on the MHOAC. There are 32 established Local Advisory Councils across the state: Central SAA has 8, serving 15 counties; Western SAA has 8, serving 13 counties; and, the Eastern SAA has 16, serving 27 counties. Due to the large geographical area of the ESAA, the use of video-conferencing is being used to reduce travel costs for the SAA membership.

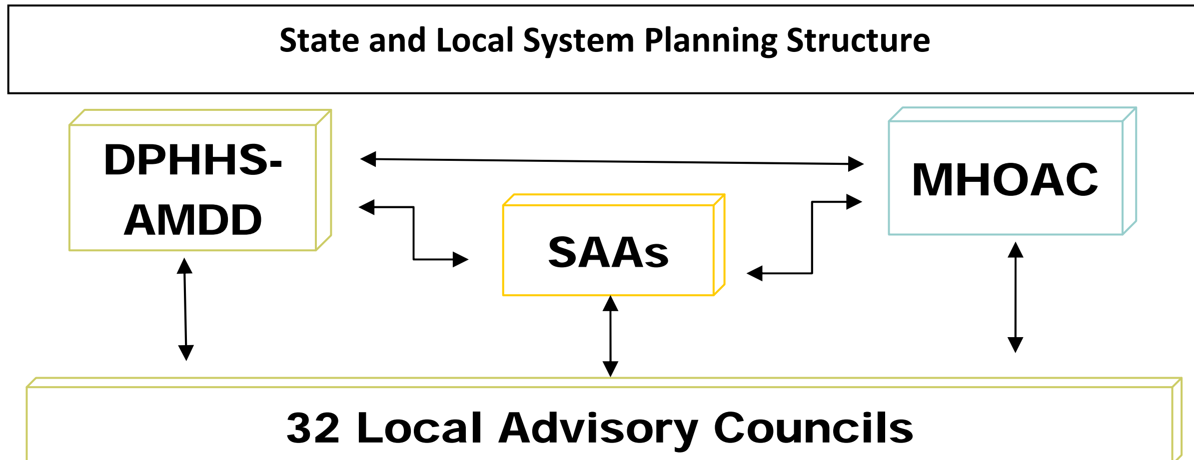
The alliance of LACs and SAAs in Montana ensures the voice of communities, locally and regionally, is recognized. Local Advisory Councils and Service Area Authorities (SAA) serve as the local network to mental health strategic initiatives in Montana. Both LACs and SAA groups are expected to include representation by consumers and consumer family members. SAA executive boards are required to have 51% consumer and family member representation.

Service Area Authorities are statutorily defined for the purpose of collaboration with the Department for the planning and oversight of mental health services within a service area. Each Service Area Authority has incorporated, adopted by-laws, and an appointed board of directors. Service Area Authorities in collaboration with Local Advisory Councils, including provider and advocacy networks work on a strategic plan that addresses the unique needs of their geographic region and population.

All three SAAs are incorporated and registered with the Secretary of State. Each Service Area Authority appoints a regional Board to provide leadership. Regional SAA Boards meet monthly to collaborate with the Mental Health Services Bureau in planning and oversight of mental health system structure and services. Each SAA holds an annual meeting to elect board members and network. Any person may become a member of the Service Area Congress if they reside within the service area and submit a membership form. Congress members have the exclusive right to elect the SAA Board. Executive Committees of the three SAAs meet quarterly to collaborate on statewide mental health planning, providing a collective vision.

The Mental Health Services Bureau continues to provide the financial and technical support to sustain the SAA system.

Service Area Authorities provide guidance to the MHSB directly and through the MHOAC for service development and planning.



Each Service Area Authority is represented on the Mental Health and Oversight Advisory Council (MHOAC) through Local Advisory Council membership. The MHOAC is the body responsible under federal statute to *"monitor, review, and evaluate the adequacy of mental health services within the State."*

The Addictive and Mental Disorders and Health Resources Divisions, and their respective mental health service bureaus are represented on the Montana Mental Health Oversight and Advisory Council (MHOAC). Together, with the assistance of the MHOAC Block Grant Committee, the Council and Divisions develop and implement the Community Mental Health Services Block Grant and adult and children's state mental health state plans.

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)? For Adults, through local and state process explained above. (MHOAC, LACs and SAAs). Children: The state is in the process of implementing high fidelity wraparound process statewide. This is a process that assists the family to take responsibility for their own team and for their treatment. A Peer-to-Peer Specialist works alongside the facilitator to guide the family in identifying their needs, natural supports and in developing a plan for the family. Two of three statewide wraparound coordinators have been hired; they will train and credential facilitators and coaches to ensure fidelity to the model.

- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs? The Department provides financial supports to NAMI for training activities. The state has hired a family liaison position whose job, in part, is to develop training for family members. She has utilized NAMI Basics curricula to teach families how to advocate for their needs. A session on the NAMI Basics for Providers training was presented by its developers from Kalispell at the Systems of Care Committee meeting. A YouthMove chapter has been developed in Helena and other areas are considering forming chapters.

- Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns? Yes through Local Advisory Councils (LACs), Service Area Authorities, and Mental Health Oversight Advisory Council. The State of Montana has an active System of Care Community group that meets four times per year. This group is comprised of family members, advocates and providers. They give feedback to the State on system development, gaps in services and have active involvement in implementing solutions.

- How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system? The wraparound process allows the family to identify the issues they want to address and then are able to brainstorm with their team, ways to get those needs met. Since the team consists of at least 50% non-paid (natural) supports, often the solutions are not paid supports, but supports provided by family members and friends chosen by the family to assist them in this process.

- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services? Addictive and Mental Disorders Division supports Consumer Drop In Centers with general fund dollars. The State has contracted with Parents Let's Unite for Kids (PLUK) to develop support groups across the state. So far, groups have been established in Billings, Missoula, Great Falls and Helena. Each group is facilitated by a family member and offers support to parents and youth. Helena has formed a YouthMove group made up of youth with and without mental health issues. The purpose of the group is to help dispel the stigma attached

to mental illness. Individual members of YouthMove have developed their own digital stories to share with their friends and other groups in the community. Other communities are considering development of YouthMove organizations in their areas.

M. Use of Technology

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs

M. Use of Technology - Response

Telemedicine Implementation - A statewide telemedicine system continues to be developed; the Bureau has developed a contract with a provider agency to provide psychiatric support to community hospitals, providers, and nursing homes. Doc to Doc consults will be available through telemedicine implementation. Contract components are noted below:

1. Hire or contract with an individual who has primary responsibility for oversight of the tele-psychiatry program;
2. Identify specific communities that have a need for psychiatric support and resources;
3. Work with health care providers in identified communities to develop community specific approaches to bringing psychiatric support to the community.
4. Develop, manage, and maintain network infrastructure for linkage and communication with identified sites including issues related to equipment and technology, licensing, credentialing, liability, medical records, accreditation requirements and applicable state and federal laws.
5. Recruit, train, and develop psychiatrists skilled in the delivery of psychiatric services using technology;
6. Establish up to 20 hours per week of psychiatric consultation and/or liaison with local communities to meet needs as identified in community specific approaches developed in (part-3)above.
7. Explore additional funding and partnerships for all statewide implementation of network; and,
8. Report progress including participating sites, utilization, and outcomes, in a format agreed to by the Department.

AMDD contracts with Trilogy Integrated Resources to support the Network of Care website, a Centralized Service Information website for Montanans with the following objectives:

1. Develop a simple, fast, and centralized manner for consumers, their caregivers, and providers to find out what appropriate community services are available to them.
2. Develop an online capacity for consumers to maintain a personal information record that could also be used by care coordinators.
3. Develop significantly improved community access to information and services for all consumers, including people with disabilities, people with limited or no English literacy skills, and for low-income individuals.
4. Provide timely and accurate educational materials to be available on the web sites regarding diseases and conditions, medications and treatments, care management issues, prevention, early intervention, planning, consumer advocacy and protection, and other related topics on Mental Health.
5. Provide a mechanism for greater communication and advocacy among consumers.
6. Develop easy access to information about local and state programs and assistance.

The Network of Care for Behavioral Health website became fully operational June 2009. The Department continues to work with stakeholders, providers, and advocates to ensure the site is a

viable, accurate and an up-to-date information resource for individuals and families needing mental health information, services, and referrals. A recovery oriented feature of The Network of Care site is the ability for individuals to put their Wellness Recovery and Action Plan (WRAP) online and give access to their supporters. Network of Care brochures have been developed and distributed to promote and market the service. The site may be accessed: http://montana.networkofcare.org/mh/home/index.cfm.

The Mental Health Association of Montana received funding for a statewide, telephone and internet-based drop-in center in 2008. The Virtual D-I collaborates with existing community resources to provide activities that are not available through or included in mainstream mental health systems. In addition, because it is phone- and internet- based, Virtual D-I will outreach to every corner of the state, including the many communities that are too small or remote to sustain a site-based Drop-In-Center.

The Virtual Drop In Center financially supported by Addictive and Mental Disorders Division (AMDD) has three components:

Warm Line: All responders re consumers of mental health services in various stages of recovery.
Warm Line Responder Training and Recruitment: Responders are paid and volunteer
Virtual Consumer Services: Telephone and internet-based social networking activities.

N. Support of State Partners

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

N. Support of State Partners - Response

State Partners Addictive and Mental Disorders Division will rely on and partner with the following agencies to assist in implementing the priorities identified in the Plan:

Priority 1: Mental Health/Recovery Services for Individuals with Severe Disabling Mental Illness who are Uninsured or Underinsured.

Addictive and Mental Disorders administers the Mental Health Service Plan (MHSP). MHSP is funded through State general funds. AMDD has been working with Centers for Medicare and Medicaid (CMS) for several years to provide and support the MHSP program and clients through a physical health benefit. In 2010 Montana was approved for the Waiver – not titled the MHSP Waiver. This waiver will provide a physical health benefit for those up to 150% of poverty, who are eligible for the Montana Mental Health Services Plan (MHSP), and not eligible for Medicare. Montana chose to designate priority populations for the Waiver services – persons with a diagnosis of schizophrenia and those with bi-polar disorder will be first and second priority, respectively.

The MHSP Waiver supports the MHSP Program by providing a physical health benefit to those MHSP qualified clients. The physical health benefit provides bi-directional health care for those who would not be able to otherwise afford physical health coverage.

Addictive and Mental Disorders Division (AMDD) partnered with the State Human and Community Services Division, Office of Public Assistance to train AMDD staff to be able to enroll and maintain clients eligible for Basic Medicaid benefits (MHSP Waiver eligible). OPA continues to be available as a partner to train AMDD staff on Medicaid rules, provide assistance as needed, and collaborate with AMDD staff on cases that require both agencies to maintain.

Although not directly involved with the MHSP Program, collaboration with health home development and implementation of the Affordable Care Act in Montana will ultimately impact those eligible for the MHSP. Montana has been working on the development of medical homes since 2009 when Montana Medicaid was awarded a technical assistance grant from the National Academy for State Health Policy (NASHP). The purpose of the grant was to assist state teams developing policy improvements so the medical home can be implemented effectively and efficiently for Medicaid and CHIP beneficiaries. In seeking to maximize the opportunity the grant could offer, the Montana team decided early on to convene stakeholders, including other major payers, to work on a multi-payer initiative rather than focusing solely on Medicaid.

Recently, the Montana Commissioner of Securities and Insurance (CSI) agreed to convene the stakeholder group and continue the efforts begun through the NASHP grant. Due to anti-trust issues, all stakeholders felt CSI was the best entity to lead the group. The Department of Public Health and Human Services, including Addictive and Mental Disorders Division, continue to serve as stakeholders.

The stakeholders group provided the Medical Home definition and recognition criteria. The stakeholder group agreed that NCQA level I recognition should be achieved in order to be

recognized by the State, in addition to some standards that address areas specific to Montana's culture and demographics.

Montana Medical Home Definition
In Montana, a patient centered medical home is health care directed by primary care providers offering family centered, culturally effective care that is coordinated, comprehensive, continuous, and, when possible, in the patient's community and integrated across systems. Health care is characterized by enhanced access, an emphasis on prevention, and improved health outcomes and satisfaction. Primary care providers receive payment that recognizes the value of medical home services.

Montana Medical Home Practice Recognition Standards- NCQA Level I *Plus*
The following standards will be used to assess and recognize providers and/or practices as medical homes in Montana. The standards were derived from the medical home definition constructed by the Montana Medical Homes Stakeholder Group. The Montana standards include NCQA Level I recognition and additional standards based on the Montana specific medical home definition.

NCQA Level I Must Pass Standards
1. PPC1A: Written standards for patient access and patient communication
2. PPC1B: Use of data to show meeting this standard
3. PPC2D: Use of paper or electronic-based charting tools to organize clinical information
4. PPC2E: Use of data to identify important diagnoses and conditions in practice
5. PPC3A: Adoption and implementation of evidence-based guidelines for three conditions
6. PPC4B: Active support of patient self-management
7. PPC6A: Tracking system for tests and identify abnormal results
8. PPC7A: Tracking referrals with paper-based or electronic system
9. PPC8A: Measurement of clinical and/or service performance
10. PPC8C: Performance reporting by physician or across the practice

Priority 2: Development of Quality Community Mental Health Services that Support Recovery and Community Integration through Employment.

Partners include: Vocational Rehabilitation; Dartmouth University; and the National Association of State Mental Health Program Directors (NASMHPD). In March 2011, AMDD contacted NASMHPD to request technical assistance and potential training in the area of Evidence Based Supported Employment. NASMHPD has been partnering with Dartmouth Psychiatric Research Center to promote and implement Individual Placement and Supports (IPS) principals in chosen programs. NASMHPD and Dartmouth staff met with AMDD and made the decision to introduce concepts and principals of IPS to licensed mental health centers through a day long training. The training was held in July and approximately 35 participants from mental health centers and State Vocational Rehabilitation attended.

Dartmouth Psychiatric Research Center was also willing to visit a potential IPS site to review employment practice. The fidelity review will be used to review possible implementation challenges and for quality improvement only.

Addictive and Mental Disorder Division (AMDD) will be working with Dartmouth Psychiatric Research Center and the National Association of State Mental Health Program Directors (NASMHPD) to discuss possible next steps to implementation of Individual Placement and Supports (IPS) principles and practice in Montana.

O. Table 12: Behavioral health Advisory Council Composition by Type of Member

Total Membership	26		
	Individuals in Recovery (from Mental Illness and Addictions)	8	
	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	4	
	Vacancies (Individuals and Family Members)	0	
	Others (Not State employees or providers)	3	
	Total Individuals in Recovery, Family Members & Others	**15**	**57.69%**
	State Employees	7	
	Providers	4	
	Leading State Experts	0	
	Federally Recognized Tribe Representatives	0	
	Vacancies	0	
	Total State Employees & Providers	**11**	**42.31%**