Each priority area is enormous in scope. For each of the priorities, could we identify 2-3 specific aims to focus on? Within each, I'd suggest having 1-2 short-term, achievable projects along with long-term projects. This will demonstrate progress within each priority area and hopefully increase broad stakeholder engagement in the priority areas. Early "wins" are needed. I'd also suggest including a few short-term, high risk-high potential yield pilots that are not very expensive, but which, succeed or fail, will tell us something useful about larger potential projects.

Infrastructure needed:
Need a standardized way to measure the impact of programs.

- Identification of validated measures that are informative, quantitative, and easy to use
    - Need to collect data using the same measures so it can be compared across systems
        - Identify what outcomes are most useful for making programming or funding decisions
    - Self-reported measures reduce rater bias
    - Can use technology to capture self-reported data on much larger scale (reduces workforce time and training)
- Centralized data collection and analysis
    - What data are already available?
    - How can data be efficiently compiled to facilitate analyses?
    - Logical choice is a center for data collection and analysis (DPHHS?)
- Regular reporting
- Publicly available information so organizations can use data to inform their programming/services

Can we consider new models to connect individuals to care and improve the quality of the care they receive? This would reduce many of the issues common to each priority area. Here are some examples:
Increasing access to care and care coordination services would reduce many of the issues identified across all priorities. Some states (e.g., MA) use a centralized care coordination service, paid for by counties, which people can use to be directly connected with the care they need. This reduces effort for the patient and provider as patients are matched to providers that accept their insurance/Medicaid/Medicare and have the expertise needed for their medical issue. The provider workload is decreased because all intake forms can be completed and patients on waitlists can be quickly scheduled when there is an appointment opening, reducing wait times. Montana 2-1-1 or something like this, could be expanded to include these services. Providers could pay into the system, along with counties, to sustain the program.

Another option would be to institute more "drug" courts. Instead of punishing people for having a SUD, they could receive mandated care, potentially reducing the strain on the

judicial branch. These courts would need a sustainable funding source. There are too few in Montana at present to meet the need.

Models like **Collaborative Care** (different than Integrated Behavioral Health and resulting in better patient outcomes) improve patient outcomes. How can we encourage use of evidence-based treatments and models of treatment into clinics/healthcare systems? Collaborative Care also addresses some major workforce issues. MAPP-Net is working on collaborative care and Project Echo (way to improve the quality of specialized care delivered by PCPs). There is also a mental health consultation line available for PCPs via MAPP-Net funding (Billings Clinic).

- Collaborative care extends the reach of mental health specialists (psychiatrists)
- Care managers monitor patient outcomes on individual and population levels to ensure patient treatment is appropriate and effective. These workers do not need a college degree. They can be trained to effectively manage data and use algorithms to guide treatment provided by PCPs.

Increase the **training and support for PCPs**. PCPs deliver a majority of mental health care, but most do not have specific training in mental health beyond a 1-month rotation in residency in psychiatry, if that. There are tools that PCPs could use to improve diagnoses of mental disorders and improve treatment planning. For example, digital, structured diagnostic interviews can be used to improve diagnoses of mental disorders. Having a care team, such as that used in the collaborative care model, provides specialist guidance on treatment of patients by a psychiatrist.

- Increased screening for common mental health conditions decreases time to diagnosis and appropriate treatment. Outcomes are better with early detection.
- Can we implement screening in contexts that would result in the majority of people being screened?

Can technology be harnessed to increase access to services post-release/discharge? What are the major barriers to delivering care via telecare for different patient types? For example, do most people have smart phones? Do they have sufficient data plans that they could receive care and provide check-in data?

- Using digital collection, data on a statewide scale could be collected to monitor who benefits from telecare and in which contexts.
- Improved outcome measurement
- Increased access to care
- Early identification of treatment non-response or need for stepped-up or -down care
- Monitoring the fidelity of patient outcomes to identify providers needing additional training or supervision

Increase education of the population about available MH/DD resources. Many people do not know about 9-8-8 despite a lot of advertising. If people know where to go BEFORE there is a crisis, they are more likely to get help before the crisis arises. There

are a LOT of services available, but most people don't know about them. Would we want to work on ways to educate the population about different types of resources using Extension Agents or other community organizations? Having a centralized resource database (run by the proposed data collection and analysis center) could act as a repository for resources that the public could use for free. That, in combination with stakeholder-guided methods for sharing data about resources, could increase people's access to care.

Current Priority Areas (revised)

Comprehensive statewide crisis system
Quality crisis systems include crisis response by trained individuals and, when appropriate, crisis stabilization services. Montana lacks sufficient and effective crisis services in both the developmental disability and behavioral health (including MH/SUD) service systems. These gaps result in a reliance upon expensive and inappropriate interventions, including law enforcement, jails, emergency rooms, and the Montana State Hospital (MSH). The Department of Public Health and Human Services (DPHHS) is working to align behavioral health crisis services with SAMHSA's Crisis Now Model for consistency of delivery. The system requires an overhaul to leverage federal, state, local, non-profit, and faith-based funding streams, ensure all programming is evidence-based and aligned with national best practices, integrate services throughout the continuum of care including the criminal justice system, and foster local innovation.

Special consideration will need to be given to integrating crisis services for individuals with developmental disabilities. The crisis system in Montana has several critical stakeholders, including hospital systems, primary care providers, behavioral health providers, first responders, law enforcement, justice systems, and the state-run health care facilities system.

Clinically appropriate state-run health care settings and a functional commitment system
Montanans often must travel great distances to receive intensive behavioral health or developmental disabilities services. Additional capacity is necessary at the community or regional level to care for our friends and neighbors in significant need including when discharging from an inpatient setting. DPHHS partnered with Guidehouse to proactively launch an initiative designed to identify and implement promising and best practice approaches to improving access to regional behavioral health and developmental disabilities service settings, with a focus on reducing overdependence on state-run health care facilities and ensuring civilly and forensically committed and other individuals in the care of the State are being served in the most clinically appropriate settings.

Furthermore, the Commission seeks to improve supports to state and local entities to streamline civil and forensic commitments, with an emphasis on reducing backlogs of individuals awaiting forensic evaluations and/or fitness restoration within local detention facilities and improving discharge planning/care coordination for all committed populations.

Capacity of adult behavioral health service delivery system
The Commission is committed to supporting a comprehensive continuum of care to address the behavioral health needs of adults in Montana. The array of services for adults is robust, but not all services, both in-person and virtual, are available in all locations across the state. There are gaps of coverage that put strain on existing services and providers, as well as increase the risk that individuals do not receive needed and clinically appropriate treatment services as close to home as possible.

Insufficient local preventive, outpatient, and intensive services can exacerbate admissions to MSH and other state-run health care facilities. Crisis response and stabilization weaknesses impact many community health and safety services as outlined above. Support and collaboration with existing providers, community partners, and consumers is needed to expand and promote the continuum of care to ensure that individuals have access to needed services.

Capacity of children's mental health service delivery system
To increase timely access to the appropriate level of care for youth and families, the capacity of the children's mental health delivery system must expand. Capacity shortfalls exist in preventive services, outpatient and intensive community services, and residential services.

The lack of in-state psychiatric residential treatment facility capacity drives Montana children and families to seek care out of state. Insufficiently trained workforce availability continues to prohibit providers from offering more services. The Commission will continue to focus on targeted workforce development, which is an approach to strengthen our system of care for youth and families by improving the skills, knowledge, and competency of frontline service providers.

Family focused home, school-based, and community services and widespread preventive services should continue to be prioritized. Increasing access to preventive services and high-quality, family-focused, community-based services, will positively impact on child and family well-being by supporting families to keep children in their homes, neighborhood schools, and communities. These circumstances permit children to be able to retain critical bonds with natural supports, including friends, family members, and faith or community-based organizations, which can offer additional positive informal supports to the child and family.

Capacity of DD service delivery system
Increasing the capacity of the Developmental Disability service delivery system is an important priority for the broader behavioral health system. To effectively provide community-based services, the Developmental Disabilities Program (DDP) would benefit from a broader continuum of care, including preventive, residential and crisis services. For example, increasing access to appropriate treatment for youth with intellectual and developmental disabilities would result in better long-term outcomes as well as minimizing escalation into higher levels of care. Ensuring proper supports are available for youth transitioning from high school into adulthood is also an essential aspect of improving the DD service delivery system.

Increasing the number of enrolled DDP providers, especially in rural areas, would assist with access to both preventative and long-term services. Supporting existing providers to improve work force recruitment and retention strategies will also result in more members accessing appropriate services and avoiding overly restrictive settings including criminal justice settings.

Capacity of co-occurring populations service delivery system
Individuals with co-occurring behavioral health and developmental disabilities challenges have unique and complex needs. In the current behavioral health system, this population is growing and experience challenges accessing appropriate services. This is because often neither DD providers nor behavioral health providers feel qualified, or are ill-equipped, to meet all the members' needs, which results in no services, inadequate services or at times inappropriate institutionalization in state-run health care and criminal justice facilities.

Montana has very few settings where individuals with a co-occurring behavioral health and developmental disability can be served. Clinically appropriate prevention services available for youth with co-occurring behavioral health and developmental disabilities are limited leading to less effective treatment and/or inappropriate residential placements.

The providers who do serve individuals with co-occurring disorders often require additional support to identify, train, and retain staff. The skill levels required to provide quality care to these Montanans are higher, the jobs can be more hazardous, and the employees may burn out faster. Case managers typically specialize in one population or the other and often do not have information about all services a member with IDD and BH should be accessing.

Family and caretaker supports (BH & DD)
The Commission is committed to aligning the program requirements of our behavioral health and developmental disabilities services with goals to strengthen families/caregivers and increase capacity and skills in caring for their family members.

Given Montana's highly rural nature and ongoing health care provider workforce shortages, families/caregivers can play an outsize role in the care delivery for individuals with a behavioral health condition and/or developmental disability. More supports, such as enhanced respite care and training and school-based services, may be required to further support those caring for individuals outside of a traditional health care setting.