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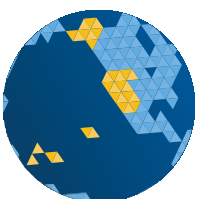
September 2022

THE PLANNING AND DEVELOPMENT OF MONTANA'S CRISIS SYSTEM

AN ASSESSMENT AND REPORT OF EVOLVING CRISIS SERVICES AND PROGRAMS

Prepared for

The Montana Department of Public Health and Human Services,
Behavioral Health and Developmental Disabilities Division



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An Assessment and Report of Evolving Crisis Services and Programs

Western Interstate Commission on Higher Education – Behavioral Health Program (WICHE-BHP)

September 2022

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During the course of WICHE-BHPs assessment and technical assistance services, we interviewed over 50 stakeholders and subject matter experts each of whom has played, and continues to play, a pivotal role in the evolution of crisis services for the people of Montana. Their perspective, experience and knowledge informed our work in Montana and this report. We especially wish to acknowledge the following leaders for educating us about their communities, sharing their insights and information, connecting us to key informants, and most importantly, for their passion and dedication to the cause.

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METHODOLOGY

WICHE-BHP employed a number of approaches to assess Montana's mobile crisis and crisis receiving and stabilization services, including:

- Interviews with 50 key informants and stakeholders representing Montana's behavioral health and health care policy makers, administrators and providers, first responders, consultants, and advocates as well as interviews with out-of-state behavioral health and crisis system providers, consultants and subject matter experts.
- Remote attendance at county-level and statewide planning meetings including: BHDD's monthly Crisis Planning Coordinator's Network meeting; Crisis Learning Community meetings hosted by Montana Healthcare Foundation and Montana Public Health Institute; project meetings with BHDD's Mental Health Bureau staff and 988 coordinator; and monthly county-level planning coalition/committee meetings.
- Site visits, including tours of existing crisis receiving and stabilization facilities and meetings with providers, planners and key informants in Billings, Butte-Silver Bow, Bozeman, Great Falls, Helena, Kalispell, and Missoula.
- Review of research and assessment reports conducted by consultants engaged by DPHHS/BHDD, Montana Healthcare Foundation, and counties regarding behavioral health services and systems, including the extensive and in-depth assessments and reports prepared by JG Research Associates and Loveland Consulting.
- Literature and research published by the Substance Abuse Mental Health Service Administration (SAMHSA), the National Association of State Mental Health Program Directors (NASMHPD), Center for Medicare & Medicaid Services (CMS), NRI Inc., RI International, Kaiser Family Foundation, National Institute of Health, National Suicide Prevention Lifeline (NSPL), the National Council on Behavioral Health Wellbeing, the National Alliance of Mental Illness (NAMI), and Mental Health America.

Per BHDD's request, in addition to assessing Montana's crisis services and systems, WICHE-BHP team offered technical assistance to seven (7) counties: Butte-Silver Bow, Cascade, Flathead, Lewis and Clark, Gallatin, Missoula, and Yellowstone. The technical assistance was driven by the specific requests of the counties' Crisis Planning Coordinators (many of whom are also managing other programs and projects for their organization and/or community) and Planning Committee members. As a result, in some communities WICHE-BHP played a more active consulting role, whereas in others our involvement was negligible.

In our meetings and discussions with stakeholders in each of the seven counties, we were educated about their plans and challenges in regard to operating crisis services. We were also able to identify their strengths and promising practices. Their individual and collective contributions to the crisis system and their approach to crisis services are highlighted in this report.

TERMINOLOGY AND DEFINITIONS

Consistent utilization of key terms and definitions can facilitate programmatic consistency and deter confusion and misunderstanding among planners, policy makers, funders, and providers as well as the individuals who receive the services. Throughout our interactions with key informants, we noted a pattern of ambiguity and common understanding of crisis service terminology. For example, what one community defines as “Crisis Receiving Facility” another defines as “Crisis Stabilization Facility”. *To support adoption of common terms and their definitions, as well as for simplicity and consistency in this report, we utilized the following terms and associated definitions.*

Behavioral Health Urgent Care: A term adopted by both community-based crisis receiving providers as well as hospitals. It refers to a specialized, short term, intervention, and treatment option as a diversion from unnecessary hospital and emergency room utilization. Whether operated by a hospital or a community behavioral health provider, Behavioral Health Urgent Care Services mirror crisis receiving services: triage, assessment, observation, evaluation, counseling, medication management and care coordination.

Crisis: A mental health crisis is a situation in which a person’s thoughts, emotions, and behaviors can put them in jeopardy of harming themselves or others and/or put them at risk of being unable to care for themselves or access food, clothing, and shelter. Crises also include acute conditions that could quickly deteriorate into dangerousness or inability to care for self, even if those issues do not currently pose a problem.¹

Crisis Continuum of Care: Crisis care provides services to anyone, anywhere, at any time. Four essential elements comprise the crisis continuum of care: 1) prevention; 2) intervention; 3) stabilization; and follow-up.

Crisis Intervention: Crisis intervention is a short-term technique used to address an immediate behavioral health emergency, stabilize the individual in crisis, and create and implement a safe, appropriate plan for next steps and future treatment.

Crisis Now Model: The *Crisis Now* model is a continuum of three components intended to prevent suicide, reduce the inappropriate use of emergency rooms and correctional settings, and provide the best supports for individuals in crisis; they include: (a) **A regional or statewide crisis call center** that coordinates in real time with the other components; (b) **Centrally deployed, 24/7 mobile crisis teams** (ideally, a clinician and a peer) to respond in-person to individuals in crisis; and (3) **23-hour receiving center and short-term stabilization center**, which may be operated separately or jointly, offering a safe, supportive and appropriate behavioral health crisis placement for those who cannot be stabilized by call center clinicians or mobile crisis team response.

Crisis Receiving Center: A community-based outpatient facility operating 24/7 with a length of stay no longer than 23 hours 59 minutes where individuals in crisis receive rapid, short-term, assessment, intervention, treatment and counseling.

¹ [Understanding Crisis Services: What They Are and When to Access Them \(psychiatrictimes.com\)](https://psychiatrictimes.com)

Crisis Stabilization Center: A community-based home-like facility at which both voluntary and involuntary treatment is provided to help stabilize individuals and avoid inpatient psychiatric hospitalization. Length of stay may range anywhere from 24 hours to three or more weeks.

Crisis Respite Care: Crisis respite is a short-term, residential facility that offers a restful, step-down environment from more intensive level of care, such as crisis stabilization or hospitalization, with support for individuals experiencing a crisis.

Emergency Psychiatry Assessment Treatment and Healing Units (emPATH): Hospital-based emPATH's are specialized psychiatric urgent care programs affiliated with the hospital emergency department and analogous to an Intensive Care Unit dedicated to emergency behavioral health patients and staffed by behavioral health and psychiatric professionals.

Mobile Crisis Teams (MCT): Mobile Crisis Teams (MCT) are comprised of behavioral health professionals and paraprofessionals who respond in the community to crisis calls that entail a mental health and/or substance use issue. MCTs help intervene, assess, and deescalate the situation. When necessary, MCTs will partner and collaborate with the first responders to resolve the crisis call and connect individuals to appropriate care.

Psychiatric Emergency Services (PES): Psychiatric Emergency Service is a hospital-based receiving site for involuntary and high-acuity psychiatric detentions. PESs typically accept voluntary/self-presenting individuals, but most patients tend to be on involuntary holds and arrive via police or ambulance. These programs offer immediate assessment and treatment (including medication) with 23-hour crisis stabilization capacity.

EXECUTIVE SUMMARY

For over 10 years, Montana's Department of Public Health and Human Services/Behavioral Health and Developmental Disabilities Division (DPHHS/BHDD) has developed programs, policies, and funding mechanisms to cultivate behavioral health crisis services for Montana. They've made significant efforts into understanding evolving needs, evaluating options for rural and frontier services, and partnering with behavioral health providers to assess the complexity of behavioral health options across the state. Guided by a strategic vision that "all [crisis] programs are evidence-based and aligned with national best practices", the Department adopted three key strategies which have successfully impacted the development of behavioral health crisis services and an evolving crisis system: 1) collaborate with stakeholders; 2) educate providers and policy makers; 3) understand service gaps and local needs to inform planning and resource allocation.

The provision of funding has been particularly instrumental in the planning and development of Montana's crisis system. Chief among funding opportunities is the Department's Crisis Diversion Grants (CDG)². Focused on *"Support[ing] crisis intervention and jail diversion efforts that prevent unnecessary restrictive placements such as incarceration, hospitalization or commitments to the Montana State Hospital,"* the CDG funding framework has stimulated coalition building and resulted in locally driven initiatives for all stages of program and system development -- from analysis and planning to start-up and adoption of best practices in crisis services, including the *Crisis Now* model. The Department's efforts to seek Medicaid waivers and assess provider rates, as well as the Governor's HEART Initiative are also key to the progress being made in crisis services.

As plans for crisis services evolve, DPHHS/BHDD and local planners have determined the continuum of crisis services (within the broader continuum of behavioral health care) requires bolstering and technical assistance. Intending to build a continuum of crisis care across the state, DPHHS/BHDD has worked to incrementally develop Montana's crisis system, which, as of this report, includes Butte-Silver Bow, Cascade, Flathead, Gallatin, Lewis and Clark, Missoula, Yellowstone, Park and Lincoln Counties. In addition, DPHHS/BHDD collaborates with other funding entities and key stakeholders, including the Montana Healthcare Foundation and the Montana Public Health Institute; together they support community coalitions, system mapping, and strategic planning activities across the state. DPHHS/BHDD has also engaged consultants to assess and provide important perspective and data relative to the operation of Montana's behavioral health system, including jail diversion, inpatient care, and crisis services.

In July 2021, DPHHS/BHDD engaged Western Interstate Commission on Higher Education - Behavioral Health Program (WICHE-BHP) to support planning efforts occurring in Cascade, Lewis and Clark, Gallatin, and Missoula Counties for Crisis Receiving and Stabilization Facilities. Considered "Phase 1" of WICHE-BHP's engagement, WICHE-BHP offered decision-making information for DPHHS/BHDD and the four counties specific to *Crisis Now* facility models and best practices, including utilization projections.³

² Formerly "County Tribal Matching Grants"

³ Per the State's strategic goal to "create and maintain sustainable, evidence-based programs," WICHE-BHP utilized the *Crisis Now* model endorsed by the Substance Abuse Mental Health Services Authority (SAMHSA) for comparative analysis, assessment, and directional assistance to local communities.

In October 2021, DPHHS/BHDD engaged WICHE-BHP in “Phase 2”, adding assessment of Montana’s mobile crisis developments and technical assistance for three additional counties: Butte Silver-Bow, Flathead, and Yellowstone. This report is a culmination of WICHE-BHP’s Phase 2 assessment of Montana’s evolving behavioral health crisis services and system.

Collaboration has been the underpinning of the State’s and counties’ progress in planning and launching behavioral health crisis services. State administrators, local planners, healthcare administrators, practitioners, advocates, funders, elected officials, concerned and dedicated citizens have come together to improve crisis services for the people of Montana. Their collective focus and determination are resulting in gradual implementation of community-based crisis services and the advancement of a crisis system of care in Montana. Highlights of their contributions and achievements include:

- ⇒ **Commitment to the *Crisis Now* Model:** With the *Crisis Now* model as their beacon, DPHHS/BHDD continues to facilitate the adoption of evidence-based crisis services. As a result, local planners and coalitions reference the Crisis Now model as they work to build crisis programs in their communities.
- ⇒ **County-level Coalitions and Collaboration:** Funded in part by the DPPHS/BHDD Crisis Diversion Grants and the Montana Healthcare Foundation, the county-level planning coalitions continue to make progress in the design and implementation of crisis services in their counties.
- ⇒ **State-level Collaboration:** There is a strong and productive collaboration between DPHHS/BHDD, the Montana Healthcare Foundation, and Montana Public Health Institute. Their collaboration is positively impacting the planning and development of crisis services across Montana.
- ⇒ **Elected Officials Leadership:** Montana’s legislature, Governor Gianforte, and local elected officials have consistently supported the development of behavioral health crisis services. Their interest and investment are a cornerstone of effective and sustainable behavioral health crisis systems at both state and local levels.
- ⇒ **Public Funding:** If not for public funding, the crisis services being planned, launched, and expanded would not be occurring. State appropriations, the HEART Initiative, Crisis Diversion Grants, federal funding, and Medicaid waivers, as well as city, county, and mill levy funds have been instrumental in the planning, operation, and continued development of crisis services.
- ⇒ **Hospital Investment:** Montana’s hospitals have been increasing their leadership in the development, delivery, and funding of behavioral health urgent care and crisis services.
- ⇒ **FQHCs Investment:** Montana’s Federally Qualified Healthcare Centers (FQHCs) have been providing integrated physical and behavioral healthcare for over 30 years. The FQHCs are making important contributions to Montana’s crisis continuum of crisis care.
- ⇒ **Certified Community Behavioral Health Clinics:** Montana’s behavioral health providers are securing millions of dollars in federal funds to prepare for and implement Certified Community Behavioral Health Clinics (CCBHCs). If adopted and endorsed by the State, the CCBHC model could strengthen Montana’s continuum of care, including crisis services.

⇒ **Workforce Development:** Comprised of multi-disciplinary stakeholders, Gallatin's Workforce Development Committee has devised a strategic plan to grow the behavioral health workforce. The Committee's work could serve as a model for other counties -- and perhaps the state.

DPHHS/BHDD requested WICHE-BHP offer recommendations for the development of Montana's crisis system based on our assessment and the technical assistant services provided. Top among our recommendations is:

1. **System Planning and Implementation Support:** We highly recommend DPHHS/BHDD adopt a process to regularly engage leaders and experts representing key components of Montana's crisis system to advise on and support the planning and implementation of multi-county/regional crisis services. To be most effective, the engagement should include high-level executives and experts who have in-depth knowledge and influence in healthcare and behavioral health systems, funding, and policies.
2. **Regionalization:** A regional approach to crisis services will help alleviate capacity, access, and sustainability challenges. Montana's highly valued philosophy regarding locally controlled services is a significant factor when considering regional configuration. Therefore, it is recommended DPHHS/BHDD begin with regional or multi-county demonstration programs.
3. **Capacity Building:** Building capacity to operate and sustain crisis services is a heavy lift that requires time, talent, and resources to successfully implement. It is important to identify where potential to build capacity exists. Stakeholders, experts, and key informants identified three (3) primary opportunities for DPHHS/BHDDs: 1) Certified Community Behavioral Health Clinics (CCBHCs); 2) Community Mental Health Centers and the Continuum of Care; and 3) Workforce Development, including telehealth.
4. **Accountability:** As Montana's crisis system evolves, DPHHS/BHDD's responsibility for ensuring providers meet standards of care for the people they serve will increase. Establishing the state's standards for crisis services and programs, including key performance measures, is critical. Having data reporting systems to support accountability and reporting is equally crucial to evaluating the system of care and its impact on the people of Montana.
5. **Implementation Plan:** DPHHS/BHDD is making progress toward its vision and strategic direction. Crisis services, particularly mobile crisis, are beginning to take root at local levels but a plan specific to the complexities of a crisis continuum of care is missing. DPHHS/BHDD and Montana's providers would benefit from an implementation plan to realize BHDD's goal of a "well-coordinated crisis system."

Statewide systems of care, such as Montana's, have taken years to develop and amend which invariably leads to an increased level of complexity. This is commonly seen across the United States as we attempt to preserve past initiatives, while adjusting to present needs and reforms. Montana, however, is in an ideal position to not only improve crisis services, but to build capacity for current and impending evolution within their healthcare system. To that end, the people of Montana are engaged, involved, and enthusiastic to create a crisis services system that benefits the lives of all who live, work, and visit the State. This continued work will take time, planning, investment, and leadership. However, the outcome will be a healthier system of care that will ultimately preserve resources and save lives.

KEY FINDINGS

Per BHDD's request, this report offers both high-level and in-depth assessment of Montana's emerging mobile crisis, crisis receiving, and crisis stabilization services. Given that both mobile crisis and crisis receiving and stabilization services operate within a continuum of care, 988 and other key programmatic and structural elements of Montana's crisis system are also addressed.

Statewide Progress and Achievements

Collaboration has been the underpinning of the State's and counties' progress in planning and operating crisis services. The number of planners, administrators, practitioners, advocates, organizations, consultants, and elected officials dedicating their time and resources to planning and building crisis services across the state is impressive. From state to local levels, their collective focus and determination is resulting in the gradual implementation of crisis services in communities and the advancement of a crisis system in Montana. For example:

- **Commitment to the *Crisis Now* Model:** With the *Crisis Now* model as their beacon, DPHHS/BHDD continues to facilitate and support the development of evidence-based crisis services. The work on policies and funding strategies will positively impact the implementation and operation, as well as sustainability and accountability, of crisis services across Montana.
- **County-level Coalitions and Collaboration:** Funded in part by the DPPHS/BHDD Crisis Diversion Grants and the Montana Healthcare Foundation, the county-level planning coalitions continue to make progress in the design and implementation of crisis services in their counties. Their thoughtful planning has entailed system mapping, data sharing and analytics, hours of planning sessions, and collaboration with multidisciplinary, multi-organizational stakeholders.
- **State-level Collaboration:** There is a strong and productive collaboration between DPHHS/BHDD, the Montana Healthcare Foundation, and Montana Public Health Institute. Focused on supporting the local communities' crisis system planning efforts, their collaborative work is positively impacting the planning and development of crisis services across Montana.
- **Elected Officials Leadership:** Montana's legislature and Governor have continued to support the development of behavioral health crisis services as evidenced by SJR14 to study Montana's publicly funded mental health system (including crisis services), the legislatures' appropriation of state general funds for crisis services, the current provider rate study, and Governor Gianforte's HEART initiative. The focus on and investment in behavioral health and crisis services by state leadership is a cornerstone of effective and sustainable behavioral health and crisis systems at both state and local levels.
- **Public Funding:** If not for public funding, the crisis services being planned, launched, and expanded, especially in the state's most populated counties, would not be occurring. Legislative appropriations such as HB-660, the Crisis Diversion Grants, federal funds, Medicaid, city, county, and mill levy funds have been instrumental in the planning, operation, and continued development of crisis services. The Mobile Crisis Teams now operating in Cascade, Lewis and Clark and Missoula Counties, and the soon-to-be-opened Crisis Stabilization Center in Bozeman are just a few examples of how public support and funding is incrementally leading to the development of a crisis service system for Montanans.

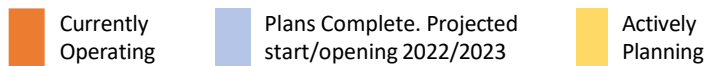
- **Hospital Investment:** Montana's hospitals are increasing their leadership in the development, delivery, and funding of crisis services. For example, Bozeman Health has entered into a contract with a nationally recognized provider of crisis care, Connections Health Solutions, to operate a Crisis Receiving Center (CRC) fully aligned with the *Crisis Now* model. In Lewis and Clark County, Shodair Children's Hospital is exploring a partnership with Saint Peter's Health to jointly run Emergency Psychiatry Assessment Treatment and Healing Units (emPATH) for youth and adults. Finally, in Yellowstone County, the substantial financial and in-kind support Billings Health and St. Vincent's Hospitals have provided to the Community Crisis [Receiving] Center in Billings has been critical for the CCC's operations and sustainability.
- **FQHCs Investment:** Federally Qualified Healthcare Centers (FQHCs) have been providing integrated physical and behavioral healthcare for over 30 years. Montana's FQHCs appear to be expanding their role in Montana's crisis continuum of care, including operating (or planning to operate) crisis services for the communities they serve. Examples of the FQHC's leadership and investments in crisis services include Alluvion Health's operation of Mobile Crisis for Cascade County, Community Health Partners' partnership with Connections Health Solutions to operate Gallatin County's Mobile Crisis Services, and Greater Valley Community Health Center's operation of Mobile Crisis Services in Kalispell.
- **Certified Community Behavioral Health Clinics:** Montana's behavioral health provider organizations are gaining momentum and securing millions of dollars in federal funds to prepare for and implement Certified Community Behavioral Health Clinics (CCBHCs). If adopted and endorsed by the State, the CCBHC model could advance and strengthen Montana's continuum of care, including crisis services. Importantly, the CCBHC Certification Criteria, which all CCBHCs must adhere to, requires the provision of crisis mental health services available and accessible 24-hours a day, including: 1) 24-hour mobile crisis teams; 2) emergency crisis intervention services; and 3) and crisis stabilization services.
- **State Policies, Rules, and Funding:** The Governor's Office and DPHHS/BHDD is working at the state and federal level to update its' rules and policies to support the development and financial sustainability of crisis services. This includes the passage of the HEART Initiative, the Provider Rate Study, and submission of Medicaid waivers or state plan amendments.
- **988:** Finally, during the course of our work with Montana, DPHHS's successfully launched Montana's 988 crisis call line. Operating 24/7/365, the 988 service is crucial to both the State's and the nations' behavioral health crisis system. Although the roll-out of Montana's 988 service was not a component of WICHE-BHPs work, we wish to acknowledge that its implementation is a major achievement by DPHHS and pivotal to the rapid response and triage of crisis calls.

County-level Progress and Achievements

The focus of WICHE-BHP's engagement with Montana's DPHHS/BHDD was twofold: 1) assess Montana's crisis services and systems of crisis care; and 2) offer and provide technical assistance to seven of the state's highest populated counties: Butte-Silver Bow, Cascade, Flathead, Lewis and Clark, Gallatin, Missoula, and Yellowstone. Each of the counties are at differing stages of program development, as highlighted in the table below.

Montana's Crisis and Behavioral Health Urgent and Inpatient Care Services

As of August 30, 2022 (with hospitals included)



	Mobile Crisis	Receiving Center	Stabilization Center	emPATH or PES ⁵	Inpatient
Butte-Silver Bow	Currently Operating	Actively Planning	Currently Operating		
Cascade	Currently Operating				Currently Operating
Custer				Plans Complete. Projected start/opening 2022/2023	
Flathead	Currently Operating	Actively Planning	Plans Complete. Projected start/opening 2022/2023		Currently Operating
Gallatin	Plans Complete. Projected start/opening 2022/2023	Plans Complete. Projected start/opening 2022/2023	Plans Complete. Projected start/opening 2022/2023		Actively Planning
Lewis and Clark	Currently Operating	Plans Complete. Projected start/opening 2022/2023	Plans Complete. Projected start/opening 2022/2023	Actively Planning	Currently Operating
Lincoln	Currently Operating				
Missoula	Currently Operating	Plans Complete. Projected start/opening 2022/2023	Currently Operating		Currently Operating
Ravalli			Currently Operating		
Yellowstone	Actively Planning	Currently Operating		Currently Operating	Currently Operating

During the course of our work, we were impressed by the counties' and stakeholder's focus and determination to build and/or expand crisis services for their communities. The plans, programs, and accomplishments highlighted in this report are intended to demonstrate how each county is customizing and developing their crisis services relative to their specific needs and resources.

- **Butte-Silver Bow:** Community Counseling and Correctional Services, Inc. (CCCS) in Butte has publicly announced it will open a crisis facility in 2023/2024. The facility will either be a new build to be located on CCCS property or a renovation of a SCL/St. James Hospital-owned space. Both organizations will financially contribute to the building. This collaborative approach is a notable example of how two major health and community – in this case a hospital and community corrections agency – are partnering to fill a void in crisis services.
- **Cascade:** In response to community need, including the police department's request for support to handle crisis calls involving behavioral health, Alluvion Health, the FQHC in Cascade County's, has taken the lead in developing and operating the Mobile Crisis Services for the county. Alluvion Health was the first FQHC in Montana to operate mobile crisis services in Montana.
- **Flathead:** Serving a large geographic area, including Kalispell, Whitefish, Columbia Falls, and Bigfork, Flathead County's Crisis Assistance Team (i.e., mobile crisis team) is a partnership between Flathead City-County Health Department and Greater Valley Health Center (GVHC). Currently in start-up stage, the Team is comprised of a program coordinator (clinical supervisor) who is employed by GVHC and oversees the program, one full-time co-responder employed by GVHC who works with first responders on scene, and one full-time care coordinator employed by GVHC who works to prevent future crisis calls by following-up with individuals served by the MST and facilitating linkage to care.

⁵ emPATH (Emergency Psychiatric Assessment, Treatment, and Healing units) and PES (Psychiatric Emergency Services) are hospital-based urgent and emergency care programs specifically for behavioral health (crisis) care.

- **Lewis and Clark’s Crisis Facility, “Journey Home”:** Built in 2014 and owned by Lewis and Clark County, the “Journey Home” is a facility specifically designed to support the operational components of the *Crisis Now* model for crisis receiving and stabilization services. The design includes a designated law enforcement entrance for warm hand-off and space for both voluntary and involuntary (i.e., emergency detention) care -- all within a safe and secure home-like setting and conducive to clinical observation, treatment and recovery. In addition, the facility is located in a residential neighborhood on a small campus owned by Many Rivers Whole Health (formerly Center for Mental Health), which also operates outpatient behavioral health and peer support services on campus. Although Journey Home is not currently operating, the County has issued an RFP for a new provider to reopen and operate the facility as a crisis receiving and stabilization center.

- **Gallatin’s Partnership with a Nationally Recognized Provider:** Gallatin County is developing a partnership with Connections Health Solutions, an Arizona-based company that operates nationally recognized crisis receiving and stabilization centers in Pima (Tucson) and Maricopa (Phoenix) Counties. The partnership includes a contract between Bozeman Health and Connections in which Connections will manage and operate a crisis receiving and stabilization facility serving Gallatin County. In addition, the County released an RFP to contract with a qualified behavioral health provider to manage and operate Gallatin’s Mobile Crisis Team which will include a partnership with the FQHC, Community Health Partners.

- **Missoula’s Mobile Support Team:** Managed and operated by the Missoula Fire Department (MFD), Missoula’s Mobile Support Team (MST) is a co-responder model comprised of Licensed Clinical Social Workers/Licensed Clinical Professional Counselors and an EMTs employed by MFD. Once it has staffing and funding capacity to operate 24/7/365, Missoula’s MST will operationally meet the key standards of the *Crisis Now* model, especially in regard to staffing - i.e., law enforcement officers do not serve on the team.

- **Yellowstone’s Community Crisis Services:** Describing itself as the “first point of access for crisis stabilization and referral for ongoing support,” the Community Crisis Center (CCC) in Billings is Montana’s only 24/7/365 crisis receiving center for stabilization and therapeutic support. The CCC provides short-term (less than 24 hours) voluntary behavioral health crisis care and accepts both walk-ins and individuals transported by first responders. In addition to the CCC, there are two model crisis prevention programs which, notably, are operated by Billings Downtown Business Alliance: the Homeless Outreach Team (HOT) and the Motivated Addiction Alternative Program (MAAP); both provide crisis prevention and intervention services through active street outreach and alliances with community providers and resources, including the Billings Police Department and the Community Crisis Center.

Capacity Challenges.

There is clearly momentum and determination to build and/or improve crisis services and systems at both state and local levels. However, we noted broad consensus among stakeholders concerning the capacity to build and sustain a crisis system. Workforce, funding, and access to community-based behavioral health care (i.e., the “continuum of care”) underscore those concerns.

- A. **Workforce:** Montana, like many parts of the country, is experiencing significant challenges hiring and retaining behavioral health professionals and paraprofessionals.⁶ The fact that multiple behavioral health services and initiatives are operating, expanding or being planned -- including 988, Mobile Crisis, Crisis Receiving and Stabilization Centers, hospital-based behavioral health urgent and inpatient care, and jail-based behavioral health services -- increases competition and adds to the challenge of recruiting and retaining skilled staff.
- B. **Funding:** As providers forecast operating costs and project budgets, a shortfall of income sufficient to meet operating expenses for 24/7/365 crisis services becomes evident. The funding challenges arise from the fact that crisis providers largely rely on reimbursed (primarily Medicaid) income based on utilization. However, providers must staff for full coverage regardless of daily utilization; yet if the number of people served each day is inconsistent (which may be the case, especially in less densely populated regions), funding from reimbursement income is insufficient to cover 24/7/365 operating expenses.
- C. **Coordinated System of Care:** Funding shortfalls and workforce challenges have impacted the behavioral health system of care -- resulting in gaps in Montana’s continuum of care. There is consensus among stakeholders, especially among those working on the “frontline”, that the scarcity of community-based behavioral health care, including mental health and substance use treatment, is creating (and, as crisis services expand, will intensify) gaps in the service continuum and the ability to coordinate care. That is, people may receive rapid crisis intervention and stabilization services however, once stabilized, may have limited or delayed access to ongoing treatment and recovery services -- thus increasing the likelihood of a revolving door and repeatedly utilization of crisis services.
- D. **Accountability Structures:** Currently, Montana lacks sufficient accountability and performance management systems to track and evaluate the quality and impact of crisis services as well as the system overall. As the crisis system develops and the number of providers increases, DPHHS/BHDD’s need for accountability, data sharing, and program quality reviews will become increasingly necessary for evaluation, reporting, policy setting, and resource allocation.

⁶ The workforce shortage has hit rural communities hard and is particularly pronounced within state Medicaid programs. A national study revealed that rural counties have 1.8 licensed behavioral health providers per 1,000 Medicaid enrollees. This is a stark contrast to urban counties with 6.4 licensed behavioral health providers per 1,000 enrollees.
<https://www.sciencedaily.com/releases/2018/05/180517102343.htm>

RECOMMENDATIONS

The following recommendations are intended to provide system development considerations and strategies to DPHHS/BHDD leadership as it works to diminish barriers and form a statewide system of crisis care for the people of Montana.

1. System Planning and Implementation Support

We recommend DPHHS/BHDD adopt a process to regularly engage leaders and experts representing key components of Montana's crisis system to advise on and support the planning and implementation of multi-county/regional crisis services.

Importantly, the engagement should include high-level executives, experts, and decision makers who have in-depth knowledge and influence in healthcare and behavioral health systems, funding, and policies, including CEOs (or their designated executive-level staffer) of Montana's Hospital Association, Healthcare Foundation, Primary Care Association (FQHCs), Behavioral Health Association, Public Health Institute, Native American Tribal leaders, the National Alliance on Mental Illness (NAMI), and Mental Health America. Specific subject matter experts should also be engaged as needed to provide feedback or consultation as indicated by region or focus.

2. County and Tribal-Level Planning Coordinators, Coalitions, Committees

We highly recommend BHDD, Montana Healthcare Foundation, and Montana Public Health Institute continue to facilitate educational forums with planning and program coordinators. Training on best practices in crisis service programs, policies, and reporting, as well as strategies for funding crisis services, benefit both the local coordinators as well as the advancement of the crisis system overall.

The Crisis Diversion Grants through DPHHS/BHDD currently fund county and tribal-level coordinators responsible for facilitating crisis system planning committees and coalitions. Additionally, in partnership with Montana Healthcare Foundation (MHF), and the Montana Public Health Institute (MPHI), BHDD hosts monthly meetings with the planning coordinators during which crisis services, practices, and implementation strategies at local, state, and national levels are discussed. This support, training, and engagement of county and tribal-level coordinators has been an effective method of sharing both state and local level approaches to building crisis policies and services.

3. Regionalization

It is recommended the state adopt a multi-county or regional model of behavioral health crisis services.

Based on our interviews with key informants and stakeholders, there is broad consensus a regional approach for mobile crisis and crisis receiving/stabilization centers could help alleviate capacity challenges. Given Montana's population bases, geography, and workforce, it is impractical and not economically feasible to expect each county and tribe to have the full array of services in the crisis continuum of care (i.e., dispatch, mobile crisis, crisis receiving, crisis stabilization, follow-up care and support) -- especially in the frontier and sparsely populated areas of the state. However, a multi-county or regional approach is feasible. A model we suggest (and stakeholders also pointed to) is the "hub and spoke" model. In this model, basic services are provided in a community to ensure the individual experiencing a crisis can be assessed in a safe environment, stabilized briefly if possible, and then transported to a longer-term facility (i.e., crisis receiving and/or crisis

stabilization) as needed. The “hub and spoke” system enables individuals to receive care in their own community, close to family and friends, and in an environment with which they are familiar. It also increases the likelihood that a local behavioral health service provider (where they exist) can be involved from the beginning and throughout the course of treatment.

It is recommended the state consider moving toward a regionalized crisis system by funding one regional crisis service demonstration project within each of the three 988 catchment areas.⁷ DPHHS/BHDD would offer technical assistance and support to the three demonstration sites. Mirroring the State Crisis System Advisory Council, each of the demonstration sites should be guided by a multidisciplinary leadership group representing the counties within the proposed demonstration area. The development and utilization of a bed/service tracking system as well as reporting on key performance measures for 988, mobile crisis, crisis receiving/stabilization, and aftercare would be integral to the demonstration sites.

4. Oversight of Behavioral Health and Crisis Services

It is recommended DPHHS: a) assign oversight of the 988 system, mobile crisis services, and crisis receiving and stabilization centers to the Treatment Bureau; b) build a professional team knowledgeable and experienced in community behavioral health; c) add a Crisis System Manager to the staff team; and d) consider realigning the Department to facilitate an integrated behavioral health system of care.

Montana’s 988 system will have a significant role in the state’s continuum of crisis care; as the first point of crisis intervention, it is integral to crisis services and the *Crisis Now* model. However, Montana’s 988 system is currently overseen by DPHHS’s Suicide Prevention Bureau; conversely, the development of mobile crisis, crisis receiving, and crisis stabilization centers is overseen by DPHHS’s Treatment Bureau. By assigning oversight of the 988 system, mobile crisis services, and crisis receiving and stabilization centers to the Treatment Bureau, DPHHS/BHDD can have a systemic perspective of Montana’s crisis services and, therefore, can more efficiently assess and facilitate the development of a crisis system of care for Montanans.

In our opinion, BHDD’s staff capacity to undertake the tasks necessary to advance Montana’s behavioral health system and crisis services is insufficient. For example, if (or when) Montana’s State Legislature endorse the CCBHC model, BHDD will need staff capacity to undertake administration of the CCBHCs and all of its’ concomitant authority, functions, and responsibilities - including ensuring the CCBHC’s adhere to required programs, quality measures and practices for crisis services. DPHHS/BHDD should consider building a professional team knowledgeable and experienced in community behavioral health programs, policies, and oversight.

⁷ Our recommendation to utilize the 988 catchment areas as the demonstration sites is tied to the fact that 988 is crucial and integral to crisis prevention and intervention systems. Given Montana has already defined three 988 catchment areas, it seems those areas offer a practical starting point for demonstration sites and eventually regionalized services.

In addition to increasing the BHDD team overall, it is recommended DPHHS/BHDD add 1FTE Crisis System Manager to facilitate, coordinate, and evaluate the development of Montana's crisis system.⁸ Hiring a credentialed, senior-level, behavioral health professional who has in-depth knowledge and experience in programs, services and system design in an evolving landscape will be especially important for this role.

Finally, the current structure in which behavioral health is divided into separate bureaus (i.e., mental health and substance use) presents administrative oversight and system development challenges. Recognizing that as many as two-thirds of the people DPHHS/BHDD serves are likely to have both mental health and substance use (i.e., co- occurring) disorders, the state system should provide oversight and support of a behavioral health system of care. Aligning mental health and substance use into one behavioral health bureau can facilitate an integrated behavioral health system.

5. Capacity Building

As WICHE-BHP worked with both state and local stakeholders, experts, and key informants, we identified five primary capacity building challenges and opportunities for DPHHS/BHDDs consideration: A) Certified Community Behavioral Health Clinics (CCBHCs); B) Community Mental Health Centers and the Continuum of Care; C) Workforce Development; D) Telehealth Infrastructure and Implementation; and E) Funding.

i. Certified Community Behavioral Health Clinics (CCBHCs)

We strongly recommend DPHHS prepare for the administrative and systemic impact Certified Community Behavioral Health Clinics (CCBHCs) will have in Montana's behavioral health system overall and crisis system specifically.

In August 2022, Montana State Legislature's Interim Committee on Children and Family Services approved Senate Joint Resolution 14-2B as a committee bill to be introduced in the 2023 legislative session making Medicaid coverage for CCBHC services mandatory or optional. Montana's behavioral health providers and advocates hope to secure the Legislators' support. Importantly, per CMS, CCBHCs are required to provide a comprehensive range of mental health and substance use disorder services, *including crisis services* available and accessible 24-hours a day and delivered within three hours, including:

- ⇒ 24-hour mobile crisis teams;
- ⇒ emergency crisis intervention services; and
- ⇒ and crisis stabilization services.

In addition, CCBHC's must:

- ⇒ *educate individuals served* about crisis management services, Psychiatric Advanced Directives, and how to access crisis services.

⁸ More specifically, the Crisis Services Manager's purpose and role would be to: 1) facilitate and coordinate the roll out, implementation and expansion of Montana's statewide crisis services and system; 2) manage state resources designated for crisis services; 3) provide technical assistance and support to local communities; 4) advise BHDD on strategic decision points relative the state's behavioral health system; 5) evaluate and report on the impact, quality, and utilization of crisis services; and 6) prepare funding proposals and reports.

- ⇒ Maintain a *working relationship with local emergency departments* (EDs), including establishing protocols for CCBHC staff to address the needs of CCBHC clients in psychiatric crisis who come to the emergency departments.
- ⇒ Have *protocols in place with law enforcement* “to reduce delays for initiating services during and following a psychiatric crisis.”
- ⇒ Provide timely *access to ongoing outpatient behavioral health services following a crisis* and adhere to standards for the timeliness of initial screening, evaluation, and treatment planning.

The CCBHC payment model can result in funding equitable to FQHCs that will help community behavioral health providers enhance, sustain, and expand their services. We wish to stress the fact that, *in order to receive funds, CCBHCs must meet and adhere to elevated accountability practices including collection and reporting on encounter, clinical outcomes, quality improvement data, and access to community-based behavioral health services*. DPHHS, in turn, must elevate its oversight practices and report CCBHC data to CMS.⁹

If approved by Montana’s State legislature, the increase in funding and elevated accountability standards for CCBHCs can potentially have a positive impact in the development and operation of crisis services as well as the State’s behavioral health care system overall. To date, 42 states¹⁰ have adopted the CCBHC model. We strongly recommend DPHHS prepare for this systemic change and seek guidance from key policy and financing experts from states that have implemented the CCBHC model.¹¹

ii. Community Mental Health Centers and the Continuum of Care

We strongly recommend DPHHS/BHDD require the Community Mental Health Centers (CMHCs) to be actively involved in the planning and delivery of crisis services and provide evidence of active collaboration in the communities they serve. Requiring local Behavioral Health Plans¹² created in partnership with providers, advocates, and key safety net entities (i.e., hospitals, FQHC's, law enforcement/criminal justice agencies, substitute use disorder treatment providers, etc.), is one tactic which may prove beneficial.

In an effort to increase access to crisis services, DPHHS/BHDD has proposed to expand the array of approved crisis service “provider types” beyond the CMHCs and hospitals. In our opinion, expansion of provider types will help build system and service capacity. However, given CMHC’s are required to serve as the safety net for individuals with serious and persistent mental health needs, their programs and services are integral to the continuum of care and must be woven into local, regional, and statewide crisis plans, services, and systems.

⁹ https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

¹⁰ More than 430 CCBHCs are operating in 42 states, Washington, D.C., and Guam.
<https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/#:~:text=Recognizing%20the%20promise%20of%20the,plus%20Washington%2C%20D.C.%20and%20Guam>

¹¹ Kansas was the first state to recognize CCBHCs as a feasible solution to behavioral health and substance related crises. Further, Kansas is the first state to implement the CCBHC model statewide [May 2021].

¹² As a stipulation of funding, Alaska requires its CMHCs prepare and publish local Behavioral Health Plans.

Crisis presents an opportunity to engage or reengage individuals with mental health and substance use disorders in lifesaving and life-altering treatment. CMHC's are key to the system of care. Therefore, although crisis services can be operated by providers other than CMHCs, and planning can occur by not fully engaging the CMHCs (all of which may soon have secured federal funding to become Certified Community Behavioral Health Clinics [CCBHC's]), Montana risks a growing fissure or disconnect in its continuum of care. Eventually, this disconnect will impact the operation and sustainability of Montana's crisis services.

iii. Workforce Development

It is recommended DPHHS/BHDD: 1) prepare a strategic implementation plan to develop Montana's behavioral health workforce; 2) incentivize crisis service providers to include Certified Peer Specialists in their staffing configuration; 3) create training in crisis intervention for Certified Community Health Workers; and 4) support the incorporation of telehealth and telehealth-based providers.¹³

For over 20 years, WICHE-BHP has helped states develop their workforce capacity – a strategic endeavor that takes time, focused dedication of resources, and broad collaboration. Replicating the collaborative approach adopted by Gallatin's Workforce Development Committee is a model DPHHS/BHDD should consider as a state-wide plan of action. Focused on building a workforce that will serve in a wide array of professional positions and service settings (including crisis services), the Committee (a component of the Gallatin Behavioral Health Coalition), has engaged key, multi-disciplinary, stakeholders in the strategic planning work. Their well-informed plan includes educating and exposing middle and high school youth in behavioral health careers; creating internships and practicums for students entering social work, psychology, nursing, and counseling fields; creating stipends and other financial supports for students; and offering "loan repayment" programs for graduates who are practicing in their communities.

In addition, as an evidence-based strategy for building workforce, we strongly recommend DPHHS/BHDD incentivize crisis service providers to include Certified Peer Specialists in their staffing configuration. In addition to building capacity of the workforce, Peer Specialists align with *Crisis Now* best practices by modeling recovery, promoting shared understanding, and offering positive coping strategies.

In addition to Peer Specialists, placing Certified Community Health Workers trained in crisis intervention can address the shortage of behavioral health crisis workers, especially for Montana's rural and frontier communities. This would be a time and resource intensive endeavor for DPHHS/BHDD but one which has been developed and implemented in Western states for rural and frontier regions, including Alaska, New Mexico, and Washington.

¹³ Montana's workforce shortage, especially for highly trained healthcare providers and licensed behavioral health practitioners, is intensified by the numerous community-based and hospital-based behavioral health service being planned and/or operating in Montana.

Finally, DPHHS/BHDD should prepare for telehealth being integral to the state’s behavioral health and crisis system workforce. Although in-person intervention, stabilization, and follow-up will always be necessary, telehealth will be instrumental in building the state’s workforce capacity.¹⁴

iv. Telehealth Implementation and Infrastructure

Weaving telehealth into a behavioral health service delivery system requires expertise and oversight to ensure provider policies and practices meet quality and privacy standards. Toward that end, it is recommended DPHHS:

- 1) Collaborate with Montana’s behavioral health telehealth organizations, including Frontier Psychiatry, and the state’s key provider associations (i.e., Montana’s Hospital Association, Healthcare Foundation, Primary Care Association, Behavioral Health Association, and Public Health Institute) to review and draft telehealth policies and quality measures for crisis and behavioral health services.
- 2) Seek consultation and technical assistance from the National Telehealth Technology Assessment Resource Center (NTTARC)/Northwest Regional Telehealth Resource Center to develop policies, infrastructure, and an implementation plan for Montana’s telehealth-delivered behavioral health and crisis services.
- 3) Require crisis service providers that incorporate telehealth train staff on telehealth applications, security, and privacy measures.

Implementing telehealth and telecommunication infrastructure to facilitate access to care, including crisis services, is a critical planning and implementation consideration for DPHHS. The National Consortium of Telehealth Resource Centers (NCTRC) is “dedicated to building sustainable telehealth programs and improving health outcomes for rural and underserved communities”. The Consortium is comprised of two National Telehealth Technology Assessment Resource Centers (NTTARC); within the Consortium are 12 regional Telehealth Resource Centers which provide planning and technical assistance at *no cost* to qualifying clinics and organizations. Montana is served by the Northwest Regional Telehealth Resource Center (NRTRC)¹⁵. According to NTTARC, states and clinics often underestimate the time it takes to plan and operate telehealth services. NTTARCs telehealth experts can assist with service design, implementation, reimbursement, policies, licensing, infrastructure, and security.

v. Funding

It is recommended the state work toward building flexible and adequate funding streams for crisis service delivery and sustainability. DPHHS/BHDD’s efforts to streamline funding and grant opportunities, apply the findings of its provider rate study, incorporate tiered funding, and adopt alternative payment models (i.e., “bundled” rates) are important steps toward that goal.

¹⁴ The evolving engagement of Frontier Psychiatry in Montana’s behavioral health system is one example of the positive impact telehealth for behavioral health will have in Montana.

¹⁵ NRTRC which also serves Alaska, Idaho, Oregon, Utah, Washington and Wyoming; [Northwest Regional Telehealth Resource Center | National Consortium of Telehealth Resource Centers](#)

The planning and development of Montana’s crisis system has primarily been funded through several DPHHS/BHDD-led funding initiatives¹⁶. However, according to BHDD staff, while funding has sparked advancement of crisis programs, DPHHS/BHDDs funding configurations created “spending, messaging, and managing inefficiencies that result in insufficient crisis system utilization and outcome reporting and unmet needs within communities.” To address those challenges and build efficiencies, BHDD staff proposed and gained approval to decrease the number of fund types (or “buckets”) from seven (7) categories to three (3). Effective for fiscal year 2022 – 2024, Montana’s state and Medicaid funding for crisis services will fall within three buckets, as reflected in the table below.¹⁷

Funding for Diversion and Crisis Services
FY22/24 Total: \$3,850,000+

Type	Purpose	Source	Amount
1 Crisis Diversion Grants	Crisis intervention and jail-diversion programs	State General Fund; HEART Revenue; HEART Jail-based Grants; Mental Health Services Plan/State General Fund; Goal 189/State General Fund; Mental Health and Substance Abuse Block Grants.	\$3.7 M
2 Non-Medicaid Crisis Program	Crisis services (assessment, mobile crisis, stabilization) for non-Medicaid adults.	State General Fund	\$150K ¹⁸
3 Medicaid Crisis Program	Crisis services (assessment, mobile crisis, stabilization) for Medicaid-covered adults.	TBD	TBD

Streamlining the funding mechanisms and administration can stimulate the growth and expansion of crisis services by reducing the burden of applying for and managing multiple planning, implementation, and expansion grants. Additionally, funding changes may also be a mechanism for DPHHS/BHDD to support demonstration or pilot programs and/or incentives for regional crisis programs. Finally, by “braiding” funds the state may be able to help fund crisis services provided to non-Medicaid and uninsured patients in equal measure to the crisis services covered/funded for Medicaid recipients – a system improvement goal referred to by BHDD leadership as “mirrored funding.”¹⁹

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¹⁶ Importantly, the Montana Healthcare Foundation has been instrumental in funding and supporting crisis service planning efforts across the state.

¹⁷ The seven categories included: 1) Crisis Diversion Grants; 2) Mental Health Services Plans; 3) Emergency Detention Crisis Beds funds; 4) 14-day Diversion funds; 5) 72-hour Crisis Stabilization funds; 6) Goal 189 funds; and 7) HEART Initiative Jail-based Grants.

¹⁸ Proposed funding for serving non-Medicaid and uninsured individuals is \$150,000; an amount which may fall short of need depending on provider’s understanding of billing and enrollment of individuals in Medicaid and the presumptive eligibility program.

6. Accountability

With the development of crisis services rapidly unfolding in Montana, we strongly encourage DPHHS/BHDD work with key stakeholders and providers to review and adopt standards of crisis care. Based on those standards, DPHHS/BHDD should establish uniform reporting requirements, quality measures, and performance outcomes for contracted crisis service providers.

The National Association of State Mental Health Program Directors' (NASMHPD) work on minimum expectation and performance indicators for Crisis Receiving and Stabilization Centers, as well as their *"988 Convening Playbook for States, Territories, and Tribes"*²⁰ can help inform the state's standards and accountability measures for crisis services.

NASMHPD: Minimum Expectations and Best Practices for Crisis Receiving and Stabilization

Expectations and Best Practices	
Operations	<ul style="list-style-type: none">✓ Operate 24/7 365 days a year.✓ Include beds within a real-time regional bed registry system to support efficient connection to needed resources.
Intake	<ul style="list-style-type: none">✓ Offers walk-in and separate first responder drop-off options.✓ Offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders.✓ Does not require medical clearance prior to admission; provides assessment and support for medical stability while in the program.
Staffing	<ul style="list-style-type: none">✓ 24/7 multidisciplinary team able to meet needs of individuals experiencing all levels of crisis.✓ Includes psychiatrists or psychiatric nurse practitioners, nurses, licensed/credentialed clinicians, peers with lived experience.
Services	<ul style="list-style-type: none">✓ Addresses mental health and substance use crisis issues.✓ Assesses physical health needs and deliver care for most minor physical health challenges with an identified pathway to transfer the individual to more medically staffed services if needed.✓ Screen for suicide risk and violence risk and, when clinically indicated, complete comprehensive suicide risk and/or violence risk assessments and planning.✓ Incorporate some form of intensive support beds into a partner program (within the services' own program or with another provider) to support flow for individuals who need additional support.✓ Coordinate connection to ongoing care.

²⁰ [988 Convening Playbook: States, Territories, and Tribes \(nasmhpd.org\)](https://nasmhpd.org/988-Convening-Playbook-for-States-Territories-and-Tribes)

NASMHPD, “988 Convening Playbook for States, Territories, and Tribes”

Key Performance Indicators (KPIs)²¹

Call Center: 988

Data/Measures (examples)	KPI (examples)
<ul style="list-style-type: none"> Number of calls Reason for calls Number of unique episodes/callers Demographic information Call escalation (e.g., mobile crisis, crisis facility, first responder) 	<ul style="list-style-type: none"> Answer rate Answer speed Average handle time Abandonment rate Rate of calls resolved Rate individuals connected to resources/follow-up care Follow-up rate, post contact

Mobile Crisis

Data/Measures (examples)	KPI (examples)
<ul style="list-style-type: none"> Number served Referral source Number dispatched with police Coordination with other rescue services Discharge destination 	<ul style="list-style-type: none"> Time to arrival/response time Rate of crises resolved Rate of individuals connected to resources/follow-up care

Crisis Receiving and Stabilization

Data/Measures (examples)	KPI (examples)
<ul style="list-style-type: none"> Admissions Number of voluntary admissions Referrals by first responders, MCTs, hospitals, professionals Discharge location 	<ul style="list-style-type: none"> Average length of stay Readmission rate Diversion rate Rate individuals connected to resources/follow-up care Follow-up rate, post care

Once formalized, we envision DPHHS/BHDD will need to increase staffing and implement data systems so that it has the capacity to assess the impact of the crisis system, identify strengths and needs of the system, and hold providers accountable for meeting standards of care.

7. Crisis Services for Tribal Nations

It is highly recommended DPHHS/BHDD make a concerted effort to support the development of behavioral health crisis services for Montana’s tribes and reservations.

Native Americans in Montana are disproportionately impacted by a variety of health, behavioral health, and social determinants of health that may result in a tribal member (and their family) needing crisis services. One dramatic example of that is the suicide statistic among Montana’s Native Americans; according to a DPHHS report “Suicide in Montana - Facts, Figures, and Formulas” between 2011 and 2022 “the highest rate of suicide is among American Indians (32 per 100,000) although they only constitute 6% of the state’s population.”²²

Montana’s Native Americans and reservations can benefit from access to rapid and culturally appropriate crisis services. However, faced with behavioral health workforce and economic challenges, the reservations and tribes can be especially affected by the challenges of operating crisis services. Notably, Blackfeet Nation is the only tribe in Montana that has applied for and received a DPHHS/BHDD Crisis Diversion Grant.²³

To demonstrate its' commitment to the tribes' and reservations' development of behavioral health crisis services, DPHHS/BHDD may wish to consider two strategies: 1) create a funding opportunity to specifically support reservations' efforts to implement crisis services that meet best practices while also allowing for customizations compatible to and respectful of their unique tribal systems, resources, histories, beliefs, and cultures; and 2) as discussed in our recommendation on the Crisis System Advisory Council, designate one seat on the Council for a tribal leadership member who can help inform the planning efforts and ensure the state's evolving crisis system is inclusive and respectful of Montana's indigenous people.

8. Crisis Services for Children and Adolescents

We strongly encourage DPPHS, BHDD, and the Child and Family Services Division prepare an implementation plan with key stakeholders, providers, and experts (which, if instituted by DPPHS, may in fact be an appropriate undertaking for the Montana Crisis System Advisory Council), to ensure children and adolescent behavioral health crisis services are woven into Montana's crisis system.

Per our engagement with DPPHS/BHDD, the focus of WICHE-BHP's assessment and technical assistance was on crisis services for adults; therefore, we did not have in-depth or pointed discussions with key stakeholders or informants regarding crisis services for children and adolescents. However, in assessing Montana's landscape of behavioral health and crisis services (including suicide rates among children and adolescents²⁴), it became evident that a strategic planning effort is needed to assess and include crisis prevention, intervention, and stabilization services for children, adolescents, and families in Montana's evolving crisis system.

NASMHPD's brief, *"Improving Child and Adolescent Crisis Systems: Shifting from a 911 to a 988 Paradigm"* provides a concise and informative perspective into the complexities and strategies for implementing crisis services for children and adolescents.

²³ The Tribe was awarded \$101,101 CDG funds for biennial years 2021 - 2023 for crisis planning and intervention initiatives. Their approach to build crises services aligns with the CDG goal: "Support crisis intervention and jail diversion efforts that prevent unnecessary restrictive placements such as incarceration, hospitalization or commitments to the Montana State Hospital."

²⁴According to DPPHS's report, "Suicide in Montana: Facts, Figures, and Formulas for Prevention" suicide is the number one cause of preventable death for children ages 10-14 and the number two cause of death for children ages 10-14 and adolescents ages 15-24. [Suicide in Montana - Facts, Figures, and Formulas for Prevention \(mt.gov\)](https://www.mt.gov/Portals/0/Files/BehavioralHealth/Suicide%20in%20Montana%20-%20Facts,%20Figures,%20and%20Formulas%20for%20Prevention.pdf)

9. Substance Use Disorders

A crisis service system primarily or exclusively focused on mental health concerns misses a sizable portion of individuals experiencing a behavioral health crisis. It is recommended DPHHS/BHDD conduct an analysis of Montana's crisis services for individuals with substance use disorders comparable to the analysis (and, as a result, planned system improvements) for mental health crisis services, including policy reviews, funding mechanisms, and the continuum of care.

DPHHS/BHDD engaged WICHE-BHP to assess and provide technical assistance on crisis services for adults with behavioral health needs. However, as our work evolved, mental health crisis services (versus substance use disorders) became the primary focus of our work and discussions with planning coordinators, planning groups, providers, and the Bureau. Therefore, although this report and recommendations reference behavioral health services, it falls short in assessing systemic challenges, policy issues, and programmatic interventions specific to individuals in crisis experiencing substance use and/or abuse.

Indeed, discussion at the state-level regarding the provision of crisis services relevant to individuals with co-occurring and/or substance use disorders was limited. At the local level however, planners, providers, and advocates voice their concern about the lack of crisis intervention and stabilization services for individuals with co-occurring and/or substance use disorders. We surmise that the state-level separation of mental health and substance use systems may be a contributing factor. As discussed in our recommendation "Oversight of Behavioral Health and Crisis Services", integrating mental health and substance use into one bureau administration can facilitate the development of a comprehensive and coordinated behavioral health care system, including crisis prevention, intervention, and treatment services.

10. System Data and a "Bed Registry"

It is highly recommended that DPHHS/BHDD dedicate resources into a thoughtful analysis and implementation of the state's data collection and reporting system, including a bed registry.

Integral to data system is a well-informed understanding of what both the state and providers will need to effectively collect and analyze data regarding Montana's crisis system – and, importantly, to report those findings and analysis to funders, policymakers, federal agencies (e.g., CMS), and the community as a whole. Simplicity and consistency of the data points are especially important. Key Performance Indicators discussed in this report can be a starting point for the state to decide what performance measures/data points to collect. Further, analysis, consultation, and technical assistance regarding the "operating" system itself, including collection processes, privacy and security, and the interface between the state and providers, should be conducted by experts in behavioral health data management systems.

The development and implementation of Montana's Bed Registry/Bed Board is integral to the behavioral health urgent care system and required to be in place by 2024. With ties to Montana's behavioral health data system, the Bed Registry/Board has practical applications of having access to real-time information regarding utilization and availability of services, including crisis receiving/stabilization beds, inpatient psychiatric beds, and detox beds. Access to this readily available decision-making tool is essential for Montana's crisis system and crisis workers.

As WICHE-BHP engaged in the process of understanding the current status of a bed registry tool for Montana, we were notified that the State had contacted with consultants and potential vendors to review product options. While WICHE-BHP was not involved in that process, bed registries remain a key component of a well-functioning and effective continuum of behavioral health crisis care. Toward that end, the “Data and Bed Registry” section of this report offers insights from state and national organizations for DPHHS/BHDD staff, community planners, and stakeholders to consider.

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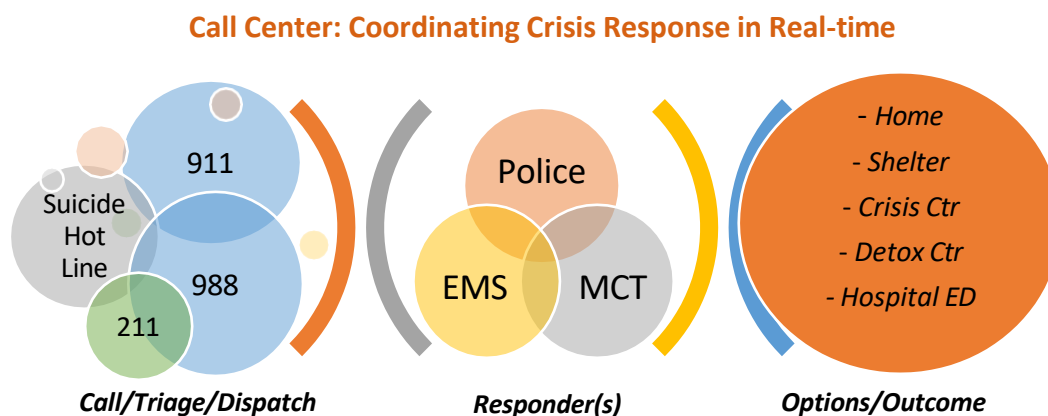
MONTANA'S MOBILE CRISIS SYSTEM

Currently there are six mobile crisis programs²⁵ in Montana, each operating at various stages of development.²⁶ Planning, implementation and expansion of mobile crisis services is primarily occurring in the state's highest populated communities.

Deployment and Dispatch

The dispatch process and triage practices for Mobile Crisis Teams is central to their effective, appropriate, timely, and safe response to crisis calls. Call takers trained and equipped to assess and triage crisis calls to appropriate levels of care are crucial to an effective crisis system. Further, collaboration and electronic connectivity between 911, 988, suicide hot lines, and 211 underpins the effectiveness and efficiency of the triage and dispatch process.

In general, there are three approaches used for crisis deployment: 1) Centralized deployment (e.g., Georgia); 2) Regional deployment (e.g., Washington and Arizona); and 3) Provider/team-based deployment (e.g., Massachusetts). As depicted in the graphic below, a regional or statewide crisis call center that coordinates in real time with the crisis services (i.e., 911, mobile crisis, crisis receiving, etc.) is a cornerstone of the *Crisis Now* model.



MCT Deployment and 988: To meet the federal requirement for a July 2022 nation-wide 988 launch, DPHHS/BHDD selected three providers: Western Montana Mental Health Center, Voices of Hope, and The Help Center. The three call centers are now providing 24/7/365 crisis line response for western, central, and eastern Montana, respectively. Like many other states across the country, Montana's 988 system is in its start-up stage.

As a new statewide and national initiative, the development and refinement of 988 practices and protocols will take time. DPHHS/BHDD should assume and prepare for the fact that as Montana's 988 develops, it will play a significant role in the State's continuum of crisis care, including triage, deployment, support and reporting for Mobile Crisis Teams, bed tracking, and system utilization. Indeed, the national "gold standard" of crisis continuum coordination entails 988 call centers

²⁵ The MCTs currently operating in Montana refer to their programs as "Mobile Crisis Response Teams", "Mobile Support Teams", or "Mobile Support Services". For simplicity in this report, the term "Mobile Crisis Team" (MCT) is used when referring to the program or model. However, when referring to MCTs operating in specific communities, the MCT is identified by the program name under which they operate.

²⁶ Once operating 24/7/365, the MCT in Missoula will be the only mobile crisis service in Montana operating per the *Crisis Now* model.

becoming “crisis care hubs”. Further, as the system matures, 988 providers will likely be able to divert some 911 calls from public-safety answering points (i.e., 911, police, fire, etc.) to the regional 988 call centers.²⁷

MCTs Deployment and 911: Connectivity and formal partnerships with 911 (and eventually 911 and 988) further the impact and appropriate deployment of MCTs. When MCTs are operated by emergency responders, such as is the case in Missoula where the Fire Department manages the MCT, this connectivity is a somewhat easy endeavor. However, for communities in which mobile crisis services are operated by community organizations versus emergency agencies (i.e., fire or EMS), creating the linkage between 911 and MCTs can be a barrier -- but one that can be overcome. Cascade County is one example.

The national “gold standard” of crisis continuum coordination entails 988 call centers becoming “crisis care hubs”. Further, as the system matures, 988 providers will likely be able to divert some 911 calls from public-safety answering points (i.e., 911, police, fire, etc.) to the regional 988 call centers.

- **Cascade MCT Model, a Dispatchable Unit with 911:** Alluvion (the FQHC) operates Cascade County’s Mobile Support Team (MST). Launched in 2017, Alluvion’s MST is now a “dispatchable unit” within Cascade County’s 911 Dispatch Center. As a dispatchable unit, the County’s 911 call takers can directly dispatch the MST to join first responders on scene. In situations where the 911 call entails a non-emergency behavioral health need or crisis, the Dispatch Center may “live transfer” the call to MST’s Stabilization and Triage Specialist; the Specialist then conducts a preliminary assessment to determine if the crisis can be handled over the phone (i.e., telehealth) or if the nature of the call is such that a MST behavioral health professional is needed – in which case the Specialist will dispatch the MST to meet police on scene. Depending on the nature of the call, the Triage Specialist may also join the MST clinician on scene.

As a fairly new dispatch and deployment practice, Alluvion Health’s MST is working closely with the County’s 911 dispatch and law enforcement agencies to refine protocols. Its agreements, protocols, and practices for triage, deployment and tracking may be replicable for mobile crisis providers that are not operated by first responder agencies.

MCTs and Global Positioning Systems (GPS): As Montana’s 988 and MCT systems develop, DPHHS/BHDD and mobile crisis providers should consider incorporating GPS systems as part of their standard operating procedures for deployment and tracking. Similar to Uber or Lyft applications, GPS for mobile crisis is programmed to identify MCTs location as well as which MCT could have the quickest response. Since the mid-2000s, many metropolitan area mobile crisis programs have used GPS programming.

Multi-County or Regionalized MCT Deployment: Washington State has regionalized deployment in which regional call centers coordinate and dispatch MCTs throughout the state. Currently, the Washington Health Care Authority allows the state’s Behavioral Health Administrative Service Organizations (BH-ASOs) discernment in triage and dispatching processes. In addition, Washington’s 988 bill (HB 1477)²⁸ identifies plans for technological advancements in 2023,

²⁷ The progression may be best approached incrementally, with physical or virtual co-location of a behavioral health crisis professional within the 911 facility.

²⁸ [Crisis Response Improvement Strategy \(CRIS\) committees | Washington State Health Care Authority](#)

including enhancing its ability to track calls, technologically deploy MCTs, and connect to a statewide bed registry. *The legislation also establishes a Tribal behavioral health and suicide prevention line “in order to enhance culturally responsive and clinical care for a traditionally underserved population.”*

This approach to deployment might be especially effective if Montana moves toward a regionalized crisis system model in which, collectively, there may be a number of MCT providers operating across multiple counties.

Mobile Crisis Models

This section of the report offers an overview of Mobile Crisis Teams (MCT) models which may be applied to urban, rural, and/or frontier communities including: 1) *Crisis Now Model*; 2) *Co-Responder Model*; and 3) *Mobile Support Model*.

In the Crisis Now highly trained and informed de-escalation and harm reduction to avoid law enforcement interventions.

Crisis Now Model²⁹ for Mobile Crisis Teams: The *Crisis Now* model for mobile crisis services has six primary operating standards and functions. The Mobile Crisis Teams (MCTs):

1. Are a **two-person team comprised of at least one licensed behavioral health professional**, (i.e., counselor, psychologist, social worker, advanced practice registered nurse, physician assistant with clinical psychiatric specialty).³⁰
2. Respond in the community, 24 hours a day, seven days a week, 365 days a year (**24/7/365**).
3. Is **dispatched to respond, intervene, assess, and de-escalate crisis events** on-scene to a range of behavioral health related crisis calls entailing psychiatric, social and/or emotional stressors, familial relations, conflicts, safety and welfare, substance use, and suicidality.
4. Engages, reconnects, refers and **links people in crisis to behavioral health support, services and treatment** based on on-scene assessment.
5. **Provides/arranges transportation** to a secondary location as indicated.
6. Provides **follow-up within 24 hours** of initial response.

Composition of the team is paramount to the *Crisis Now* model. When operating within the model standards, the team is comprised of highly trained behavioral health professionals and paraprofessionals (including Peer Specialists)³¹ who collaborate with other behavioral health specialists or medical providers.

²⁹ The Crisis Now model is endorsed by SAMHSA, NASMHPDs, the National Council for Mental Wellbeing, NAMI, and Mental Health America.

³⁰ NOTE: The behavioral licensed professional/clinician may be a remote member who is present for the total duration of the response via telehealth.

³¹ None of the currently operating MCTs in Montana employ Peer Specialists to serve on their teams. Based on research and our experience, we believe this a missed opportunity that can both enrich the crisis intervention itself as well as the follow-up services which are central to MCT standards.

In the *Crisis Now* model, *law enforcement officers are not members of the MCT*. However, providers and law enforcement agencies will resist the practice of not including a law enforcement officer as a member of the team; public safety and risk of harm to the MCT members is paramount in their concern – although whenever there is a potential public safety risk, calling for law enforcement backup and/or co-response with first responders is a standard operating procedure.

Typically, the *Crisis Now* model MCTs will have one (or more) of three staff configurations, as shown in Table #1 below.

Table 1: Crisis Now Models: Team Configurations

Team does not include LE Officer

Team Composition (2)	Qualifications	Unique Components
Medical Professional + Paraprofessional	<ul style="list-style-type: none"> 1 medic (nurse, paramedic, EMT, MD, etc.) 1 substantially trained/experienced crisis worker 	Also handles non-emergent medical issues to avoid costly ambulance transport and ER TX.
Clinician + Paraprofessional	<ul style="list-style-type: none"> 1 (Lead) clinically licensed/licensure candidate BH professional 1 BH paraprofessional qualified by education, experience, training. 	
Paraprofessional + Licensed Professional “on scene” via telehealth	<ul style="list-style-type: none"> 1 BH Paraprofessional qualified by education, experience, training. 1 licensed BH professional trained/experienced in telehealth. 	<i>BH professional may be remote (via telehealth) but is “on-scene” through duration of intervention.</i>

Currently, none of six MCT programs currently operating in Montana meet the *Crisis Now* standards. However, the Missoula MCT (operated and managed by the Missoula’s Fire Department), is comprised of a medical professional and a behavioral health professional, is dispatched from emergency services, provides or arranges transportation when needed, connects individuals to services, and conducts follow-up within 24 hours. The Fire Department is currently working toward MCT response 24/7/365; when that occurs, the Missoula MCT will be operated per the *Crisis Now* model. ³²

Co-responder Model: Operating a MCT program per the *Crisis Now* model requires a behavioral health workforce to support the staffing model as well as substantial resources to operate 24/7/365. In addition, providers and law enforcement agencies can be reluctant to have MCTs that do not include law enforcement officers. As a result, communities will adopt the co-responder model in which one member of the team is a behavioral health professional or paraprofessional and the other is a law enforcement officer, as reflected in Table 2 below.

³² In August 2022, Community Health Partners (the FQHC) in Gallatin County applied to SAMHSA for funding to launch a Crisis Now MCT model program; if funded, the Gallatin MCT will be jointly operated by Community Health Partners and Connections Health Solutions.

Table 2: Co-Responder Model: Team Configuration³³

Team includes LE Officer

<i>Team Composition</i>	<i>Qualifications</i>	<i>Unique Component(s)</i>
1 BH professional + 1 LE officer	<ul style="list-style-type: none">BH professional is licensed or licensure candidateLE officer is CIT trained	Clinical oversight provided by licensed professional (who may “be remote”)
1 Peer Specialist + 1 LE officer	<ul style="list-style-type: none">Peer Specialist is person with lived experience highly trained in safety assessment, crisis intervention, de-escalation, suicide risk, etc.LE officer is CIT trained	
1 Community Health Worker + 1 LE Officer	<ul style="list-style-type: none">Community Health Worker is trained in community health as well as in safety assessment, crisis intervention, de-escalation, suicide risk, etc.LE officer is CIT trained	Clinical oversight provided by licensed professional. Professional (who may be “remote”)

According to the National Association of State Mental Health Program Directors (NASMHPD), the co-responder model can be an effective approach to crisis intervention and stabilization:

*“Aside from reducing costs, diversions of this sort are extraordinarily important for minimizing the criminalization of mental illness and substance use disorders and ensuring people are treated in the least restrictive environment possible.”*³⁴

Currently, six of the seven operating MCTs in Montana have adopted the co-responder staffing model.

Mobile Support Teams for Rural and Frontier Communities: In rural and frontier regions in which workforce and financial constraints limit the ability to operate MCTs, Mobile Support Teams can be an effective approach.³⁵ As reflected in Table 3, Mobile Support Teams are comprised of non-licensed/non-clinical team members highly trained in crisis intervention. In this model, Peer Specialists and Community Health Workers can be especially effective when the team is not expected to be immediately or quickly on site and when supervision and consultation is provided by a behavioral health clinician.

³³ Importantly, per CMS, MCT services in which law enforcement officers comprise one team member, (co-responders), do not qualify for the highest rate of ARPA/Medicaid reimbursement. However, co-responder MCTs will qualify for lower (Medicaid and non-Medicaid) reimbursement rates per DPHHS/BHDD’s proposed tiered-funding policy.

³⁴ Assessment #4: Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit (nasmhpd.org)

³⁵ There is a lack of published research and articles regarding the efficacy of mobile support models for rural and frontier communities. However, research regarding Peer Specialists in behavioral health and Community Health Aides/Workers in health care indicate this staffing approach has promise – especially for smaller populations with limited workforce and financial resources to operate or sustain a 24/7/365 mobile crisis response model.

Table 3: Mobile Support Model

Composition	Qualifications	Unique Component(s)
2 Para-professional Crisis Specialists (Peer Specialists, Community Health Workers, etc.)	<ul style="list-style-type: none"> • May be combination of 1 Peer Specialist and 1 Community Health Worker supervised by licensed BH professional. • Highly trained in safety assessment, crisis intervention, de-escalation, suicide assessment and intervention. 	<ul style="list-style-type: none"> • Preventative in nature. • Responds to lower-level crisis calls, often to known persons. • Called in by providers, LE, FD, ED • Clinical oversight provided by BH clinician.

In a Mobile Support services model, first responders can request Mobile Support after encountering someone in need of assistance. Given travel distances and coverage, the calls for Mobile Support will most often not require immediate response; rather, they may be called to assist first responders by helping “known persons” connect to behavioral health or social services, to prevent a crisis, and/or to provide a “warm hand-off” when first responders are prepared to leave the scene but have determined the individual may benefit from the skill, assistance, and follow up of a crisis specialist.

Operating Standards for Mobile Crisis. Regardless of the model and credentials of the team, MCTs share five (5) operating standards that differentiate them as “mobile crisis” versus crisis prevention or intervention services:

1. **TEAM:** Is comprised of at least two (2) individuals highly trained in crisis intervention;
2. **FIRST RESPONDER COLLABORATION:** Collaborate with 911, 988, law enforcement, and emergency services to resolve crisis calls in the community;
3. **ON-SCENE/COMMUNITY INTERVENTION:** Help intervene, assess, de-escalate and stabilize the person on-site to minimize trauma, avoid law enforcement intervention if at all possible, and/or divert individuals who are experiencing a crisis from unnecessary utilization of jails, emergency departments, or other costly emergency services;
4. **TRANSPORT/ARRANGE TRANSPORTATION:** When needed, MCTs transport or arrange transportation to an appropriate destination or program/provider (i.e., crisis receiving center, detox center, shelter, hospital, etc.); and
5. **FOLLOW-UP/CONNECT to SERVICES:** Provides follow-up to avoid future crisis and/or to connect the person to continued treatment and support.

The Question of Law Enforcement Officers on the MCT. The *Crisis Now* model emphasizes that behavioral health professionals and paraprofessionals, versus law enforcement officers, on the MCT positively impacts both the individual in crisis as well as first responder, hospital, and criminal justice systems. By not having law enforcement on the team, the crisis intervention is more likely to focus on the behavioral health aspects of the crisis versus the nuisances of “erratic or irrational behavior” that may or may not result in minor infractions. As a result, the individual in crisis is more likely to be directed toward resources and/or treatment versus jail.

Safety and MCT Operations. The safety of its' team members and the individuals they interact with is of utmost importance to every mobile crisis provider. On this note, we think it is especially important to underscore that MCTs that do not include law enforcement officers as members of the MCT (i.e., the *Crisis Now* model) adhere to standard operating procedures and are closely partnered with and actively supported by first responder agencies, which includes:

- ➔ Written **agreements** with law enforcement and first responder agencies outlining **mutual aid** and safety protocols.
- ➔ MCTs are **assigned first responder radios with direct connection to 911/dispatch**, including **tracking MCTs enroute and location**.
- ➔ MCTs have **access to information regarding dangerous or potentially dangerous history** related to the individual or setting.

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Montana's Mobile Crisis Teams

Strong collaboration and partnerships between the MCT providers and first responder agencies are resulting in the steady adoption and expansion of mobile crisis services, especially in Montana's highest populated regions. Table 4 (below) identifies where (as of August 31, 2022) mobile crisis services are operating.

Table 4: Existing Mobile Crisis Services
As of August 30, 2022

Butte - Silver Bow Mobile Support	<ul style="list-style-type: none">• Operated by: Community Correctional and Counseling Svcs.• Composition: Paraprofessional and (remote) BH professional
Cascade Co-Responder	<ul style="list-style-type: none">• Operated by: Alluvion Health (FQHC)• Composition: BH Clinician and LE Officers
Flathead Co-Responder	<ul style="list-style-type: none">• Operated by: Greater Valley Health (FQHC)• Composition: BH Clinician and LE Officers
Lewis and Clark Co-Responder	<ul style="list-style-type: none">• Operated by: St. Peter's Hospital• Composition: BH Clinician (Team) and LE Officers
Gallatin Co-Responder	<ul style="list-style-type: none">• Operated by: Community Health Partners (FQHC)*• Composition: BH Professional and LE Officers
Lincoln Co-Responder	<ul style="list-style-type: none">• Operated by: Lincoln County Probation Dept.• Team Composition: BH clinicians and LE
Missoula Crisis Now	<ul style="list-style-type: none">• Operated by: Community Health Partners (FQHC)• Composition: BH Professional or Clinician and FD/EMT staffer

* Gallatin is in the process of contracting with Connections Health Services, an Arizona nonprofit organization operating nationally recognized behavioral health crisis centers in Tucson and Phoenix, to jointly operate the MCT with Community Health Partners (FQHC), per the Crisis Now Model.

As of this report, five (5) of the seven mobile crisis programs operating in Montana are co-responder teams. The fact that the majority of the seven counties have adopted the co-responder model (at least during their start-up phase) is not unique to Montana; the co-responder model is common across the United States.

Mobile Crisis Programs Actively in Development: In addition to the mobile crisis programs currently operating in Montana, there is one tribe and two counties actively planning, have applied for funding, and/or are incrementally launching their mobile crisis programs.

- ➔ **Yellowstone County Mobile Crisis Teams**, to be jointly operated by Yellowstone Fire Department and Rimrock behavioral health services.
- ➔ **Park County Mobile Support** (start-up), operating by L'esprit Mental Health Center.

Montana’s Mobile Crisis Providers: A certain provider or organizational type does not necessarily drive the functionality or success of a mobile crisis program. For example, as reflected in Table 6 below, the mobile crisis services currently operating in Montana are managed by health care, criminal justice, and emergency responder agencies.

It is especially interesting to note that currently *none of the six current Mobile Crisis Teams are operated by a Community Mental Health Center*. However, as of this report, Rimrock is working with Yellowstone Fire Department to replicate the Missoula MCT and jointly operate MCT for Yellowstone County. When the Yellowstone MCT is operating, Rimrock will be the first behavioral health provider in Montana to partner on MCT operations.

Table 5: Montana’s Mobile Crisis Programs: Provider Types

<i>Operated by</i>	Butte- Silver Bow	Cascade	Flathead	Gallatin	Lewis and Clark	Lincoln	Missoula
Hospital					✱		
FQHC		✱	✱				
Fire Department							✱
Criminal Justice *	✱					✱	
NPO: Contract				✱			

* Community corrections, probation depts., etc.

Program Operations and Staffing Considerations: In developing their mobile crisis programs, stakeholders are assessing their community’s and provider’s capacity. Their assessment determines the program model, team composition, and response protocols (including operating hours) they will, at least initially, adopt.³⁶ Planning and operational considerations include:

- workforce capacity,
- population and projected need,
- provider partnerships,
- cost and funding sources.

Similar to other states with few densely populated areas and where a high percentage of residents reside in rural and frontier communities,³⁷ MCT providers’ greatest challenge is a limited capacity to sustain 24/7/365 operations. In addition, Montana’s geography presents the added challenge of MCT providers meeting a standard MCT expectation: rapid response.

Despite these challenges, communities, DPHHS/BHDD, healthcare providers, elected officials, public servants, funders, and advocates continue to persevere in their planning activities and intend to find ways to have mobile crisis operating across Montana. Additionally, policy makers, providers and system consultants are assessing both access to and sustainability of crisis services -- including regional MCTs.

³⁶ Perceptions of whether every deployment of MCT is high risk and therefore requires law enforcement presence, regardless of the nature of the call, has also influenced the model MCT providers have adopted.

³⁷ Montana spans more than 147,000 square miles and has an estimated population of 1.1 million people. Approximately 43%, or 470,000, live in rural areas of the state.

Modifying Mobile Crisis Models: The value, public health impact, and systemic need for mobile crisis services is evident. However, having the capacity, especially in workforce and funding, to operate MCTs is a significant challenge faced by communities across the country. Those capacity challenges result in communities and providers choosing to modify (versus not having), their mobile crisis service.

Butte-Silver Bow: Butte’s mobile crisis services is one example of how communities and providers who, seeing a need for crisis intervention and prevention programs, may need to modify best practices while also meeting the priority needs of their community -- especially during the capacity-building phase of program development.

Policy makers, providers and system consultants are assessing both access to and sustainability of crisis services, including development of mobile crisis teams that could serve multiple counties or regions in the state.

Operated by Community Corrections and Counseling Services (CCCS), the mobile crisis team in Butte is not tied to the 911 dispatch or law enforcement call center; rather, the team is dispatched by CCCS. In its start-up phase, the “team” is comprised of one paraprofessional who responds to CCC-dispatched calls solo; a second team member (a behavioral health professional) joins remotely or in person, if available. The team does not require law enforcement presence – unless, of course, once on scene the call presents a safety risk. the paraprofessional is also dispatched to the hospital emergency department where they assist with behavioral health crisis interventions.

Training Mobile Crisis Responders

One key oversight responsibility of DPHHS/BHDD is to construct training requirements for behavioral health crisis workers. Toward that end, BHDD requested WICHE-BHP review and make recommendations for MCT staff. To inform our recommendations, WICHE-BHP reviewed the state’s current requirements in comparison to national organizations’ (CMS, SAMSHA, NASMHPD, etc.) and *Crisis Now* training guidelines. Table 6 below offers BHDD and Montana’s crisis service providers a high-level view of our recommendations.

Table #6 Training for Mobile Crisis Workers

BHDD/CDG Required	ARPA/CMS Required	WICHE-BHP Recommended Training
<ul style="list-style-type: none"> ➔ First Aid ➔ CPR ➔ Non-violent Crisis Intervention and De-escalation ➔ Suicide Risk Screening 	<p>All BHDD required training <i>plus</i></p> <ul style="list-style-type: none"> ➔ Harm Reduction ➔ Trauma-informed Care 	<p>All BHDD/ARPA-CMS required training <i>plus</i></p> <ul style="list-style-type: none"> ➔ Responder Safety Training ➔ Suicidality and Intervention ➔ Co-occurring Disorders ➔ Opioid Intervention; Administering Naloxone ➔ Crisis Intervention with Children and Youth ➔ Social Determinants and Crisis Intervention ➔ Recovery-focused Interventions ➔ Cultural Considerations ➔ Understanding and Connecting to Community Resources ➔ Telehealth Applications

BHDD’s Crisis Diversion Grant (CDG) requires, prior to provision of services, “*all Mobile Crisis Response staff must have valid certification or completed training*” in *First Aid, CPR, de-escalation training and nonviolent crisis intervention, and suicide risk screening*. In addition to the CDG training requirement, CMS/ARPA funding requires all team members to be trained in *trauma-informed care* and *harm reduction*. Per the *Crisis Now* model best practices, it is recommended BHDD also require and facilitate training in *co-occurring disorders, crisis intervention with children and youth, social determinants of health, recovery-focused care, and cultural considerations*.

De-escalation Training: Needless to say, training in safe, evidence-based crisis intervention and de-escalation techniques, and practices are crucial. Montana’s required training specifically references two nationally recognized models: Mandt System and Nonviolent Crisis Intervention training.

“With the focus on providing an alternative non-law enforcement response to behavioral health crisis, community mental health response teams must be appropriately trained to do their job safely and effectively.” - Crisis Response Consulting

The *Mandt System*³⁸ is a relationally based training program to prevent, de-escalate, and intervene in behavioral interactions before they become aggressive. Alternatively, *Nonviolent Crisis Intervention*³⁹ is a nationally recognized training to identify and respond to escalating crisis situations using evidence-based techniques, including verbal de-escalation skills, conflict disengagement techniques, tools for decision making, and physical intervention techniques. A third nationally recognized training for crisis intervention that is not currently employed in Montana but which BHDD may want to consider offering is “*Therapeutic Options*” which has been found to be highly effective in teaching various crisis staff to manage patient behavioral health outbursts and aggression while reducing the likelihood of patient traumatization. It teaches physical intervention

³⁸ <https://www.mandtsystem.com/>

³⁹ <https://www.crisisprevention.com/Our-Programs/Nonviolent-Crisis-Intervention>

and safety skills, as well as relational skills, which allow for compassionate responses and positive alternatives to the use of restraint and seclusion⁴⁰.

Training on Co-occurring Disorders and Substance Use Interventions: Given state and national statistics, crisis intervenors and practitioners are more likely than not to interact with individuals whose crisis is related to substance use and/or overuse, including opioid-related behaviors and overdosing. Hence our recommendation for BHDD's to include training in crisis assessment and interventions when co-occurring and/or substance use disorders are suspected. Further given the statistics of fentanyl related deaths overdose deaths In Montana⁴¹, training in the application of naloxone, is also crucial.⁴²

Training on Suicidality: CDG awardees (and, soon providers receiving CMS/ARPA-elevated Medicaid rates) are required to complete training in suicidality. Given Montana's suicidality statistics, we believe every crisis responder – from 988⁴³ call takers to in-person crisis intervenors -- should receive training on suicide risk assessments and interventions. The National Suicide Prevention Lifeline is an excellent resource for guidelines, policies, and training which planners, training coordinators and practitioners can benefit from. Examples of Lifeline training topics include: *suicide risk assessment standards, guidelines for callers at imminent risk, protocols for follow-up contact after the crisis encounter, and collaborative safety planning.*

Training on Trauma-Informed Care: It is increasingly evident that individuals experiencing a behavioral health crisis have an increased prevalence of having experienced and survived traumatic events⁴⁴. In addition, many crisis responders have also experienced trauma⁴⁵. Fundamentally, so as not to "re-traumatize" individuals involved in the crisis incident, all staff involved in crisis services should be trained in the principles of trauma-informed care and the use of various de-escalation and intervention skills that minimize trauma.

Trauma Informed Care is a paradigm shift from asking, "What is wrong with this person?" to "What has happened to this person?"

It is important that all staff involved in crisis services be trained in the principles of trauma-informed care and the use of various de-escalation and intervention skills that minimize trauma so as not to "re-traumatize" individuals involved in a crisis incident.

⁴⁰ <https://therapeuticoptions.com/therapeutic-options/>

⁴¹ According to the Montana Department of Justice Division of Criminal Investigation's 2021 Report "Montana Fentanyl Trends", the number of fentanyl-related overdose deaths in Montana increased by 167% from 2016 to 2020. Further, the Department believes "with high confidence that fentanyl abuse is increasing in Montana and impacting drug overdoses in the state." [DOJ-Fentanyl-Summary-2021.pdf \(mt.gov\)](#)

⁴² The Bureau of Justice Assistance's Law Enforcement Naloxone Toolkit is a clearinghouse of resources to support law enforcement agencies in establishing a naloxone program. Training guidelines and resources can be found at [Law Enforcement and Naloxone | Working with BJA NTTAC \(ojp.gov\)](#)

⁴³ It is our understanding Montana's three 988 providers are participating in training opportunities provided by Lifeline and ensuring their call takers complete the required training modules.

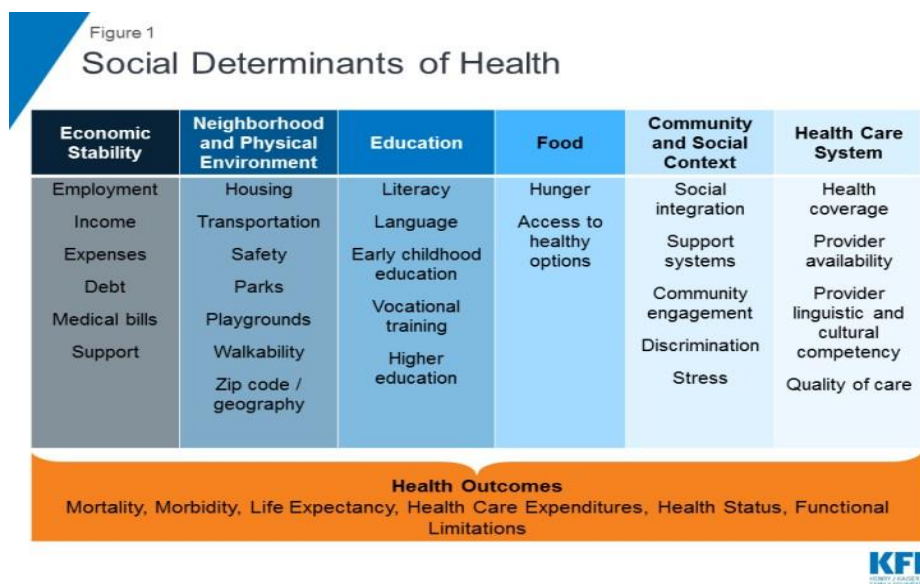
⁴⁴ Schein, et al., 2021. Prevalence of post-traumatic stress disorder in the United States: a systematic literature review. *Current Medical Research and Opinion*, 31(12): doi: [10.1080/03007995.2021.1978417](https://doi.org/10.1080/03007995.2021.1978417)

⁴⁵ SAMHSA. (2018). First responders: Behavioral health concerns, emergency responders, and trauma. [Disaster Technical Assistance Supplemental Research Bulletin](#).

It is highly recommended BHDD require training in trauma-informed care for crisis workers. Trauma-Informed Care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's treatment and recovery. It is a paradigm shift from asking, "What is wrong with this person?" to "What has happened to this person?" Two basic models of trauma-informed care training endorsed by SAMHSA can assist crisis workers, particularly non-clinical staff: 1) "The Three E's of Trauma,"⁴⁶ (i.e., Event(s), Experience, Effect); and 2) The "Four R's" (Realization, Respond, Respect, Resist).

The Three E's training illuminates the impact of trauma and how an individual's experience can influence the severity and duration of their symptoms. The "Four R's" teaches how trauma can affect people and groups and recognition of signs of trauma, as well as how to create a system with the capabilities to respond to trauma and develop practices and policies to avoid re-traumatization.

Training on the Social Determinants of Health: Social determinants of health are often interwoven into behavioral health crisis calls. As reflected in the table below, social determinants include socio and economic status, education, neighborhood and physical environment, employment, social networks, and access to healthcare.⁴⁷ Crisis workers should have an understanding of how social determinants affect individuals' physical and mental wellbeing.



Further, given the time and effort invested by crisis workers to engage or re-engage people in services, crisis workers should be trained in community resources so that they can be prepared to address and/or help alleviate social determinants.

⁴⁶ Pinals, D. A. & Edwards M. L. (2021). Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988. Technical Assistance Collaborative Paper No. 4. Alexandria, VA: National Association of State Mental Health Program Directors.

⁴⁷ "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity", [Samantha Artiga](#) Follow @SArtiga2 on Twitter and [Elizabeth Hinton](#), Published: May 10, 2018

Training on Telehealth Guidelines and Applications: In addition, as MCTs are launched and expanded across the state, the likelihood that telehealth will be embedded in the MCT system will increase. Therefore, telehealth guidelines and applications should also be a required training module for MCTs (with an opt-out for those providers that will not be using telehealth interventions).

Crisis Worker Certification Program: Finally, as BHDD looks to advance training for crisis workers, it may be interested in replicating the Utah model. In 2018, Utah created the Behavioral Health Crisis Commission to support the 988 initiative. This group went on to develop the *Crisis Worker Certification program*⁴⁸, which requires any provider working within the crisis response system to complete a State-endorsed certification training. Utah also used this initiative as an opportunity to partner with graduate programs and universities.

Utah's training protocol was developed by the State Behavioral Health Authority and requires 40 training hours for licensed behavioral health providers, bachelor's-level staff, certified peer specialists, certified case managers, and certified family resource facilitators. The minimum required training includes:

- ➔ Signs/symptoms of major mental health, cognitive, emotional and substance use disorders
- ➔ Assessment of suicidal intent
- ➔ De-escalation and behavioral management techniques
- ➔ Relevant mental health policies
- ➔ Available mental health services locally and regionally
- ➔ Crisis intervention
- ➔ Clinical assessment and addressing severe mental health issues
- ➔ Developing crisis safety plans
- ➔ Coordinating short-term crisis placements
- ➔ Disability awareness
- ➔ Mental health first aid (for police and dispatch, at a minimum)

Substance use issues, disorders, and interventions are woven into Utah's required training for crisis workers. Given the prevalence of substance use in Montana, adopting similar training requirements and policies would be beneficial for Montana's crisis workers and the individuals they assist.

It's especially important to note that substance use issues, disorders, and interventions are woven into Utah's required training for crisis workers. Given the prevalence of substance use in Montana, adopting similar training policies will likely be beneficial to crisis workers and the individuals they assist.

Reporting and Performance Indicators for Mobile Crisis

Intended outcomes for MCTs inform Key Performance Indicators (KPIs) and associated metrics to uniformly evaluate service and system utilization, effectiveness, and impact. As Montana's crisis system evolves, local planning committees/coalitions and BHDD staff have been working to establish standard KPIs for MCTs. WICHE-BHP was asked to assist in that effort by offering suggestions based on the Crisis Now model performance metrics as well as those adopted by other states and providers.

⁴⁸ <https://www.nashp.org/utahs-crisis-worker-certification-successes-and-lessons-learned>.

states and providers. Following is a compilation of those metrics and KPIs, including those being reported by MCTs currently operating in Montana.^{49 50 51 52}

Table 7: Key Performance Indicators (KPIs) and Metrics for MCTs

KPI	Metrics
1. Provided intervention and de-escalation for (#) individuals experiencing a mental health crisis -- including crisis related to substance use and co-occurring disorders	<ul style="list-style-type: none"> A. Sociodemographic data (age, gender, ethnicity, education, etc.) of each individual served B. Behavioral health presentation/diagnosis (depression, anxiety, suicidality, serious mental illness, co-occurring mental health and substance use, intoxication, substance use disorder, etc.) C. Number (#) of persons served in the community in an 8-hour shift
2. Responded Rapidly	<ul style="list-style-type: none"> A. Response Time (within 1-2 hours, though variable re: "reasonable" for specific rural location) B. Percentage (%) of calls responded to within one to two (1- 2) hours C. Longest response time D. Range of crisis response time (minimum to maximum)
3. Intervention Provided in the Community	<ul style="list-style-type: none"> A. Length of Call B. Service setting (where provided)
4. Diverted from Unnecessary Hospital or Jail-based Interventions	<ul style="list-style-type: none"> A. Facilitated emergency department redirection for (#) individuals B. Facilitated jail diversion for (#) individuals with minor infractions
5. Decreased Use of Law Enforcement and First Responders for Non-emergent and Social Determinants of Health Needs..	<ul style="list-style-type: none"> A. Number (#) of responses requiring law enforcement presence B. Number (#) of responses requiring emergency responders (fire, EMTs etc.) C. Time saved for law enforcement and emergency responders
6. Disposition (Result of Intervention).	<ul style="list-style-type: none"> A. Resolved on scene B. Individual plan in place to mitigate crisis; able to safely remain in current residence OR safely transferred to additional psychiatric care <ul style="list-style-type: none"> a. Facilitated or provided transportation to home or temporary housing b. Facilitated or provided transportation to behavioral health services, including crisis receiving, stabilization or respite center, detox, or hospital
4. Provided Follow up and Care Coordination.	<ul style="list-style-type: none"> A. Connected (#) individuals to behavioral health services B. Re-engaged (#) individuals to behavioral health providers/treatment C. Provided follow-up to (#) individuals
5. Cost Savings Due to Diversion from Higher Level of Crisis.	

CMS/ARPA Funding and Mobile Crisis

Effective April 2022, new provisions in the American Rescue Plan Act (ARPA) allow for increased Medicaid reimbursement for “qualifying community-based mobile crisis intervention services”. The revision provides up to five (5) years of additional funding to states for mobile crisis services for Medicaid eligible individuals, either through the state plan or through a waiver of the state plan. Per DPHHS/BHDD, the new provisions “... complement the resources available through the

⁴⁹ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

⁵⁰ <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-22-community-crisis-response-partnerships.pdf>

⁵¹ 988 Convening Playbook: States, Territories and Tribes

⁵² Nebraska [Continuum of Care Manual](#) for Mental Health and Substance Use Disorders

MHBG [Mental Health Block Grant] and existing CCBHCs [Certified Community Behavioral Health Clinics] to enable more robust support crisis intervention and management services.”

Given the potential fiscal and systemic impact of increased rates, DPHHS/BHDD asked WICHE-BHP to assess if Montana’s currently operating mobile crisis teams align with the CMS/ARPA requirements. Per CMS, to receive the ARPA increased Medicaid provider rate, the mobile crisis service must meet the following requirements:

REQUIREMENT	CRITERIA
Eligibility	Serves individuals who are Medicaid eligible, including those presumptively eligible, who are experiencing a mental health or SUD crisis.
Location	Services provided in the community, outside of a hospital or other facility setting.
Services	Provides screening, assessment, stabilization, de-escalation.
Team Composition	Multi-disciplinary team of two; one behavioral health professional qualified to provide assessment, the other professional/ paraprofessional with expertise in behavioral health or crisis intervention. One telehealth team member is allowed, provided the second team member is on scene/in-person. Telehealth team members must be a highly trained practitioner, i.e., psychiatrists or psychiatric nurse practitioners.
Operations	Operates and is available 24 hours a day, every day of the year.
Response	Responds in a “timely” manner, considering additional travel time needed for teams to respond in rural and remote areas.
Training	Has met state training standards and ensured all team members are trained in trauma-informed care, de-escalation strategies, and harm reduction.
Partners	Maintains relationships with relevant community partners, including medical, behavioral health, primary care, and pediatric providers, as well as community health and crisis centers.
Coordination	Coordinates with/refers to health, social and other support services.
Access	Offers language access for people with limited-English proficiency and for those who are deaf or hard of hearing.
Compliance	Complies with ADA, Rehabilitation Act and Civil Rights Act.
Privacy	Maintains beneficiary privacy and confidentiality.

Based on our assessment and a survey conducted by BHDD in June 2022, none of the seven mobile crisis programs presently operating in Montana meet all of CMS/ARPA funding requirements. In our opinion (and in the opinion of numerous stakeholders we interviewed), demographic, geographic, and economic factors collectively impact provider’s capacity to meet ARPA/CMS (and *Crisis Now*) standards. Consider:

1. **Demographic Challenges:** According to the US (United States) Census, in 2020 1,061,705 people lived in Montana; 20% of the population were over ages 65, 21% were under 18. According to the Montana State Legislature, approximately 44% of the population lives in rural areas of the state. However, according to a 2010 Montana State University Study, approximately 80% lived in or within 50 miles of the state’s seven largest urban centers.⁵³ The largest urban center is Billings with a population of just 109,705 (2020 census).

⁵³ [Montana: One State with Three Changing Regions \(Part 2 of 3\) - This is Montana - University of Montana \(umt.edu\)](#)

Given its' demographics, the state has a relatively small workforce from which to recruit; this is especially challenging for hiring highly trained healthcare providers, including licensed behavioral health practitioners. Additionally, the workforce capacity challenge is intensified by the numerous behavioral health and crisis initiatives being planned and/or operating in Montana, including 988, mobile crisis, crisis receiving, crisis stabilization centers.

2. Geographic Challenges: With just over 147,000 square mile radius interspersed with mountain range barriers between communities in much of the state, Montana's landscape presents a distinct geographic challenge to meeting one of the primary goals of mobile crisis: rapid response. Distance and travel conditions are especially challenging during winter months. Telehealth is one solution to the challenge of "getting to people" especially in rural and frontier areas;⁵⁴ however, internet connectivity in the more remote areas is a challenge to be overcome.
3. Economic Challenges: Taking into consideration 24/7/375 operations and staffing, a mobile crisis program can cost upwards of \$1,000,000 annually. Medicaid can certainly help fund a portion of those costs. However most, if not all, mobile crisis programs will face funding gaps that will require additional funding to sustain operations. Until they can secure a reliable income stream beyond Medicaid, counties and providers will likely struggle to operate or sustain 24/7/365 operations.

Acknowledging the challenges and barriers to operating mobile crisis per CMS's/ARPA's requirements, DPPHS/BHDD is preparing an amended state plan to CMS for approval of a "tiered bundled rate" strategy that will allow Medicaid reimbursement to support the array of mobile crisis services models currently operating in Montana -- although not at the higher ARPA levels. If approved by CMS, the expanded provider types, bundled rate, and qualifying team composition requirement will be effective January 2023.⁵⁵

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⁵⁴ If the State Medicaid plan amendment Waiver is accepted, mobile crisis services in which one team member is connected via telehealth, and remains "on scene" for the duration of the call, will be a reimbursable service at either the increased ARPA rate or at one the State's proposed tiered-service rates.

⁵⁵ To qualify for the higher rates, DPPHS/BHDD will require the MCT's staffing be sufficient to cover 24/7/365 response. Additionally, BHDD is considering requiring the MCT provider have a dedicated program manager and a care coordinator. However, County planners and coordinators are concerned about justifying or covering expenses for the additional dedicated staff while also sustaining the 24/7/365 MCT staff; this is especially concerning for MCTs in smaller communities.

CRISIS RECEIVING AND STABILIZATION SERVICES

A primary focus of WICHE-BHP's work with DPHHS/BHDD entailed assessing the development of crisis receiving and stabilization centers as well as providing technical assistance to the seven counties. This section of the report provides a summary of WICHE-BHP's findings based on our assessment, research and technical assistance activities.

Defining Crisis Receiving and Crisis Stabilization Services. Crisis receiving and stabilization facilities operate 24/7/365 providing crisis assessment and stabilization services as an alternative to hospital emergency departments; they are an essential element of the crisis continuum of care.

Although both are community-based facilities "crisis receiving" and "crisis stabilization" centers differ in their function and operations. However, we noted the two terms are used interchangeably in Montana which results in some confusion. For example, the Community Crisis Center operations in Billings align with the guidelines of a crisis receiving center; however, the Center's leadership refers to it as a "crisis stabilization" center.

Per the Crisis Now model, the receiving /stabilization center operates as a "no wrong door" and admits individuals for assessment and stabilization services -- regardless if they are voluntarily seeking or involuntarily needing services.

To help alleviate confusion and create consistency in policy, we suggest the state adopt definitions to differentiate a Receiving Center from a Stabilization Center and to apply those definitions in its policies and rules.⁵⁶

Capacity Challenges. Mirroring the challenges of mobile crisis services, providers, advocates, consultants, planners, analysts, funders and policy makers are keenly aware that having capacity to operate and sustain "no wrong door" crisis centers 24/7/365 is a major challenge made more complex by four factors: 1) geography; 2) population density; 3) workforce; and 4) funding.

- **Geographic Barriers:** With a landmass of over 147,000 square miles and 63 mountain ranges, Montana's vast and mountainous topography creates challenges to individuals and first responders' ability to access timely crisis services, including receiving and stabilization centers. Further, when individuals are transported by law enforcement or EMS, the round-trip transportation time which might entail over 100 miles and/or traversing mountain ranges, pulls first responders "offline" – resulting in staff shortage for responder agencies who require full coverage for the public safety of the communities and counties they serve.
- **Population Density:** The state's 2021 estimated population is 1,104,271 people – of which over 720,000 (65%) live in rural Montana.⁵⁷ Per the 2020 census, only four of Montana's 56 counties populations are greater than 100,000: Yellowstone, Missoula, Gallatin, and Flathead. Cascade's and Lewis and Clark's population fall short of 100,000 (at 84,511 and 72,223,

⁵⁶ Crisis receiving and crisis stabilization centers need not operate independently. In fact, best practices indicate that having both receiving and stabilization within one facility is optimal. National models, including the centers operating in Tucson and Phoenix by Connections Health Solutions, is one example which stakeholders and planners in Montana have visited and ideally hope to replicate.

⁵⁷ Rural Health Information/Montana

respectively) The remaining 50 counties have population bases of 50,000 and less.⁵⁸ RI International, per the Crisis Now evaluation tool, recommends providers operate up to five (5) crisis receiving recliners/beds per 100,000 people; given the population density of Montana's communities, justifying, and sustaining 24/7/365 crisis receiving and stabilization center, especially per the Crisis Now model, will be a major challenge.

- **Workforce:** The operation of crisis receiving/stabilization centers requires practitioners with advanced degrees and certifications in behavioral health, psychiatric, and substance use disorders. According to the Rural Health Information Hub, as of 2022, every county in Montana has a behavioral health workforce shortage.⁵⁹ Access to a workforce of credentialed and qualified behavioral health professionals and paraprofessionals is a major barrier for Montana.
- **Funding:** sustainable funding is a valid concern of stakeholders and providers. Not surprisingly, the cost to operate a 24/7/365 crisis receiving and/or crisis stabilization facility can easily exceed \$2 million annually -- especially when considering staff compensation and benefits, equipment, furnishings, medications, medical supplies, sanitation, food service, laundry services, training, communications (IT, phones), marketing, facility rent, improvements and repairs, insurance, legal services, data storage and management, and electronic health record exchange systems. To sustain operations and avoid closures, Montana's crisis centers will need substantial public funding over and above Medicaid and Medicare reimbursement.

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⁵⁸ The smaller county population bases indicate a need for Montana to consider regional crisis receiving/stabilization centers, as discussed in this report.

⁵⁹ Rural Health Information; <https://www.ruralhealthinfo.org/data-explorer>

Models: Receiving, Stabilization and Receiving/Stabilization Centers

In determining the crisis facilities currently operating or planned in Montana, we referred to the three models of crisis facilities per SAMHSA and Crisis Now: 1) *Crisis Receiving Center/Facility*; 2) *Crisis Stabilization Center/Facility*; and 3) *Crisis Receiving & Stabilization Center/Facility*.

Crisis Receiving Center:

- Is an alternative, but not a replacement, to a community hospital Emergency Department (ED); as such, it operates 24 hours a day, seven days a week, 365 days a year (24/7/365)
- Has walk-in and (a separate) drop-off/entrance for individuals transported by first responders.
- Is a community-based outpatient program that provides evaluation, observation, intervention, and referral for individuals experiencing a mental health/behavioral health crisis.
- Is a short-term urgent or emergent treatment for crisis intervention and stabilization of no more than 23 hours and 59 minutes from the time the individual is admitted to the program.
- Individuals receiving this service are evaluated and stabilized and/or referred to the most appropriate level of care.
- Given their function as an urgent behavioral health crisis service (i.e., less than 24 hours), crisis receiving centers are typically furnished with medical recliner chairs versus beds.

Crisis Receiving Center

Purpose	<ul style="list-style-type: none">▪ In-person, 24/7, 365 days a year▪ Support, Assessment, Rapid Stabilization (including Sobering)▪ ER and Jail Diversion▪ Refer/Link to Care
Length of Stay	▪ Under 24 hours
Capacity	▪ Typical: 4 – 24 Observation Reclining Chairs
Intake/Access	<ul style="list-style-type: none">▪ Referral Sources: Law Enforcement, Mobile Crisis, Emergency Room, Healthcare, Behavioral Health Providers, Crisis Call/Text Lines/988▪ Law Enforcement and Mobile Crisis Portal/Hand Off▪ Walk in
Admissions Policies/Criteria	<ul style="list-style-type: none">▪ All people, often related to mental health, substance use, and co-occurring issues▪ Voluntary and/or Involuntary Care (Unlocked and/or Locked facility)▪ Medical status appropriate for setting, i.e., Medical Clearance
Staffing	<ul style="list-style-type: none">▪ Professionally licensed/credentialed staff: Prescribing Nurse Practitioners, Psychologists, Clinicians, Addiction Counselors, Social Workers, consulting Psychiatrist (including tele-psychiatry)▪ Administrative Support and Security
Licensing	<ul style="list-style-type: none">▪ If operated by licensed Mental Health Center: Meets requirements of Admin. Rule MT (ARM) 37.106.1976, “Outpatient Crisis Stabilization Facility” and endorsed as Outpatient Crisis Facility.▪ If operated by licensed Hospital: Endorsed as Outpatient Crisis Facility.

Crisis Stabilization Centers

- Are short-term, 24-hours or more, of supervised residential treatment in a community-based facility of fewer than 16 beds for adults with a mental health and/or mental health and substance use (co-occurring) disorders.
- Are emergency treatment for crisis intervention and stabilization treatment option as an alternative to acute inpatient hospitalization.
- Are intended to serve approximately 30% of the admissions that are not stabilized in the 23-hour crisis receiving center.
- Includes medically monitored residential services to provide psychiatric stabilization on a short-term basis (in some programs, as long as three or four weeks).
- Operations, programs and services are designed to reduce disability and restore individuals to previous functional levels by promptly intervening and stabilizing when crisis situations occur.
- The focus is recovery to prevent continued exacerbation of symptoms and decrease need for higher levels of care, including hospitalization.

Crisis Stabilization Center

Purpose	<ul style="list-style-type: none">▪ In-person, 24/7, 365 days a year▪ ER and Jail Diversion, Alternative to Inpatient Behavioral Health Hospitalization▪ Assessment, Stabilization, Support, Treatment▪ Refer/Connect to Care
Length of Stay	<ul style="list-style-type: none">▪ 24 hours to 10 days (average length of stay, 3 days)
Capacity	<ul style="list-style-type: none">▪ Typical: 4 – to no more than 16 Beds
Intake/Access	<ul style="list-style-type: none">▪ Referral Sources: Hospital, Healthcare, Behavioral Health Providers▪ Mobile Crisis, Law enforcement, Ambulance Transfer
Admissions Policies/Criteria	<ul style="list-style-type: none">▪ Behavioral health patient needing/seeking 24 hour+ treatment but not needing hospital-level acute inpatient care▪ Typically, both Voluntary and Involuntary Treatment (Locked facility)▪ Medical Status and Clearance Appropriate for Setting
Staffing	<ul style="list-style-type: none">▪ Professionally licensed/credentialed staff: Psychiatrist, prescribing Nurse Practitioners and/or Physicians Assistants, Psychologists, Clinicians, Addiction Counselors, Social Workers▪ Peer Specialists▪ Administrative Support and Security Staff
Licensing	<ul style="list-style-type: none">▪ Licensed MHC endorsed as an Inpatient Crisis Facility per the standards for BH Inpatient Facilities (ARM Subchapter 37.106.17) plus requirements specified in ARM 37.106.1946.

Crisis Receiving and Stabilization Centers:

- To ease referrals and transfer from one to another, crisis receiving the crisis stabilization services operate in one facility or in close proximity to each other.
- The receiving /stabilization center operates as a “no wrong door” and admits individuals seeking and needing crisis assessment and stabilization services, *regardless if they are voluntarily seeking or involuntarily needing services.*
- A portion of the facility (receiving) is designed to facilitate rapid, (less than 24 hours), assessment, intervention, and stabilization; the other (stabilization) is designed for longer (24 hours and more), extended assessment and stabilization, including medication management.⁶⁰

Crisis Receiving and Stabilization Center

Purpose	<ul style="list-style-type: none">▪ In-person, 24/7, 365 days a year▪ ER and Jail Diversion, Alternative to Inpatient Behavioral Health Hospitalization▪ Assessment, Stabilization, Support, Mental Health and Co-occurring Treatment▪ Seamless transfer from Receiving Facility to Stabilization Facility/Services▪ Refer/Connect to Care
Length of Stay	<ul style="list-style-type: none">▪ Receiving: under 24 hours. Stabilization: 24 hours up to 10 days (avg. LOS, 3 days)
Capacity	<ul style="list-style-type: none">▪ 4 – 24 Observation Recliners (Receiving). 6 – 16 Beds (Stabilization)
Intake/Access	<ul style="list-style-type: none">▪ Referral Sources: Hospital, Healthcare, Behavioral Health Providers▪ Mobile Crisis Teams, Law enforcement, Ambulance Transfer
Admissions Policies/Criteria	<ul style="list-style-type: none">▪ Persons in crisis needing rapid stabilization, support, assessment and/or sobering▪ Behavioral health patient needing/seeking 24+ treatment but not needing hospital-level inpatient care▪ Typically, both Voluntary and Involuntary Treatment (Locked facility)▪ Medical Status/Clearance Appropriate for Setting
Staffing	<ul style="list-style-type: none">▪ Professionally licensed/credentialed: Psychiatrist, prescribing Nurse Practitioners and/or Physicians Assistants, Psychologists, Addiction Counselors, Social Workers▪ Peer Specialists▪ Admin. Support and Security Staff
Licensing	<ul style="list-style-type: none">▪ Licensed MHC endorsed as an Inpatient Crisis Facility per the standards for BH Inpatient Facilities (ARM Subchapter 37.106.17) plus requirements specified in ARM 37.106.1946.

⁶⁰ Per RI International, national leaders in crisis care and the *Crisis Now* model, the 23-hour crisis receiving (observation) unit uses recliners instead of beds “to maximize capacity flexibility, client flow, and create an environment conducive to dialog during the initial crisis engagement period. This component acts as a ‘psychiatric emergency department’ and accepts a sizable percentage of its admissions as diversions from jails and EDs. On the other hand, the stabilization unit is limited to 16 beds per the Institute of Mental Disease (IMD) facility requirements. Licensed as residential, sub-acute and/or hospital beds “these units are intended to serve approximately 30% of the admissions that are not stabilized in the 23-hour observation unit during the first day with an average length of stay (ALOS) between 2.5 and 3 days.”

Collaboration and Partnerships: Regardless of the model adopted, crisis receiving and stabilization centers operate on active collaboration and formalized agreements with the community's or region's provider and first responder agencies, including, at a minimum:

- 988 and 911
- Mobile Crisis Team Providers
- Law Enforcement Agencies
- Fire and EMS Agencies
- Hospitals
- FQHCs
- Indian Health Centers
- Mental Health Centers
- Substance Use Treatment Providers
- Homeless Service Providers

Montana's Existing and Developing Receiving and Stabilization Centers

Based on our assessment, none of the behavioral health crisis centers currently operating in Montana meet all the *Crisis Now* standards. However, there is momentum to open new crisis receiving/stabilization centers as demonstrated by the plans and collaborations underway in Butte-Silver Bow, Gallatin, Lewis and Clark, and Missoula Counties.

Existing Crisis Receiving Center. Although the organization's leadership refers to it as a crisis stabilization center, the **Community Crisis Center (CCC)** in Billings *is currently Montana's only crisis receiving center* providing rapid assessment and stabilization (less than 24 hours) for individuals in crisis.

Operating 24/7/365, the CCC is a nonprofit entity whose organizational structure and management model entails formal partnerships with the two hospitals in Billings (i.e., St Vincent's Healthcare and Billings Clinic) and the South-Central Montana Regional Community Mental Health Center (aka the Mental Health Center) -- each of which are allocated positions on the "owner's board". Notably, the hospitals provide substantial in-kind professional support and services to sustain the CCC's operations.

Based on our assessment, the CCC meets some of the *Crisis Now* standards. It operates 24/7/365 with licensed behavioral health professionals and nurses on staff and, importantly, accepts walk-ins and first responder transport⁶¹ as well as individuals needing minor medical care. However, the CCC does not currently meet the *Crisis Now* staffing standards -- specifically: psychiatrists, prescribing Nurse Practitioners, or Physicians Assistants are not on staff. Nor are Certified Peer Specialists on staff or part of program milieu. Additionally, there is not a separate portal for "warm hand-off" between law enforcement and the CCC staff. Finally, the CCC does not serve individuals needing involuntary (i.e., emergency detention) care.

Although it may not currently operate within *Crisis Now* standards, the CCC is a valuable resource for Yellowstone County's safety net. The CCC's facility, operating practices, and programs are especially conducive for individuals who are without a home or at risk of becoming homeless; 85% of the people served are without homes or at risk of becoming homeless; 75% of those individuals have co-occurring substance use and mental health challenges.

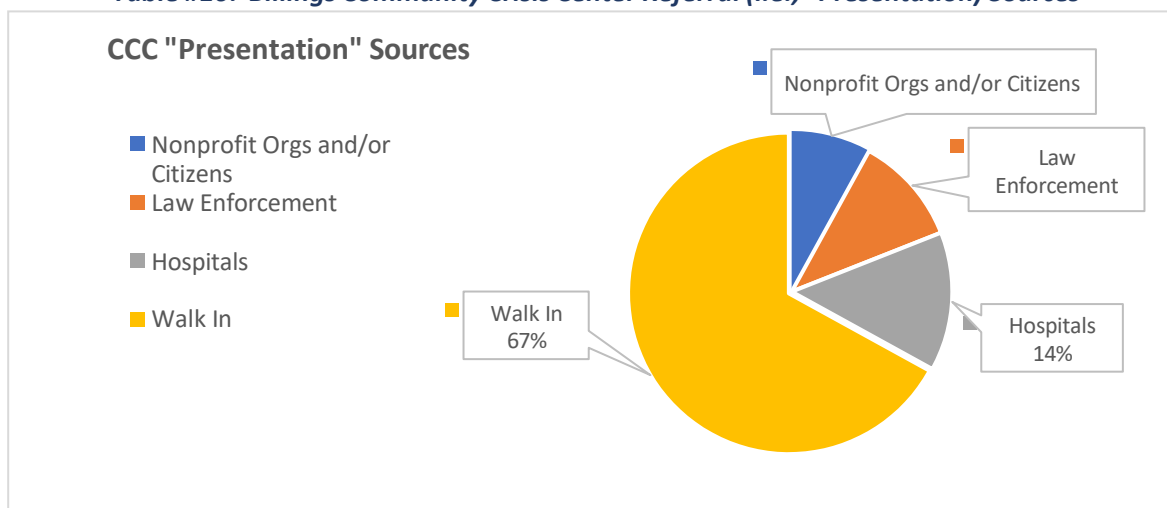
⁶¹ The CCC refers to itself as a "stabilization" center but functionally operates as a receiving center, providing less than 24 hours (23.59) of care.

As reflected in the CCC's reported utilization (Tables #9 below), except for the pandemic years, year after year, visits to the CCC have increased. In fact, as of August 1, 2022, the CCC had over 12,000 visits. Further, considering 67% of the CCC's "presentation sources" are walk-ins and another 11% are law enforcement transports, apart from not accepting emergency detention (involuntary) holds, the CCC appears to adhere to an open-door policy for individuals seeking voluntary services.

Table #9: Billings Community Crisis Center. Admissions (i.e., "Resolved" Visits)



Table #10: Billings Community Crisis Center Referral (i.e., "Presentation") Sources



The CCC has the potential to evolve and meet all the best practices in crisis receiving services.⁶² However, based on our assessment, to meet the Crisis Now guidelines, adjustments would need to be made to the CCC's staffing, operating practices, policies, and facility.

⁶² CCC's leadership and other providers looking to replicate the Crisis Now model would benefit from visiting crisis centers operating in rural and mountain regions of Colorado (a list of which was shared with CCC's and Yellowstone's planning coordinator). A site visit to the model program in Tucson, AZ would be especially insightful and helpful to observe.

Existing Crisis Stabilization Centers

Western Montana Mental Health Center’s (WMMHC) Crisis Stabilization Centers: As of August 2022, only one provider is operating crisis stabilization centers in Montana: Western Montana Mental Health Center (WMMHC). As reflected in Table #10, WMMHC operates six (6) crisis stabilization centers located in Butte- Silver Bow, Flathead, Lake, Missoula, and Ravalli Counties.

Notably, WMMHC’s Glacier House in Kalispell is the one stabilization center in Montana currently providing voluntary and involuntary placement. Further, the vast majority of Montana has no crisis stabilization services or beds.

Table #10: Currently Operating “Crisis Stabilization” Centers

County	WMMHC’s Stabilization Centers
Butte-Silver Bow	Hays Morris House
Gallatin	Hope House
Lake	Polson Lake House
Missoula	Dakota Place
Ravalli	West Hamilton House

Based on the information we were able to gather⁶⁴ WMMHC’s crisis stabilization centers do not meet the minimum standards of a *Crisis Now* model. For example, WMMHCs crisis stabilization” centers do not accept law enforcement drop off and, as a condition of admission, individuals in crisis are required to be medically cleared (typically from the hospital) if there are indications of medical need. Further, Peer Specialists are not part of the staffing model or integral to the programmatic services.

However, WMMHCs crisis stabilization centers do appear to have qualified behavioral health staff, including psychiatric oversight. Further, as the only provider in Montana operating residential crisis stabilization centers, WMMHC’s is filling a gap in Montana’s continuum of crisis care – at least in Western Montana -- especially in regard to serving individuals needing longer term, community-based, stabilization services, or crisis respite, as an alternative to, or step-down from, hospitalization.

These findings are in no way a reflection of the CCC or WMMHCs commitment to provide quality services and care to their customers or the communities they serve.

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⁶⁴ During our assessment, we had hoped to review comparative data of the six centers in regard to their capacity, access, operating hours, professional staffing, etc. We were unable to secure that information from the provider or BHDD, therefore we relied on discussions and reports shared at county planning meetings, interviews with stakeholders and WMMHC staff, and site visits to assess WMMHCs stabilization centers’ capacity and programs.

Planning for Crisis Receiving and/or Stabilization Centers: Progress and Challenges

Using the *Crisis Now* model as their guide, Missoula, Lewis and Clark, Butte-Silver Bow, and Gallatin Counties are actively formulating plans for crisis centers.

- **Missoula:** Provided financial resources are sufficient to make necessary capital improvements, cover start-up expenses, and sustain 24/7/365 operations, Missoula hopes to open a *crisis receiving center* in 2023/2024. As of this report, Western Montana Mental Health Center and Providence Hospital are considering a partnership to operate the center.
- **Lewis and Clark:** Seeking a provider to operate the currently closed Journey Home facility, Lewis and Clark County's Public Health Department has issued an RFP for operation of a *crisis receiving and stabilization center*. The county's crisis system planning committee (i.e., Behavioral Health System Improvement Leadership Team), hopes to confirm a provider by the fourth quarter of 2022.⁶⁵
- **Gallatin:** Bozeman Health Deaconess Hospital has contracted with Connections Health Solutions to operate a *crisis receiving and stabilization center* that will mirror the nationally recognized crisis facility and services Connections operates in Arizona (i.e., the Crisis Response Center). Start-up plans entail Connections opening with crisis receiving service with potential expansion to add stabilization services in the future. Importantly, subject to revised state code, both voluntary and involuntary care will be provided. Bozeman Health and Connections hope to begin operating the Center in the first quarter of 2023.
- **Butte-Silver Bow:** In May 2022, Community Counseling and Correctional Services, Inc. (CCCS) announced it will open a *crisis receiving center* in Butte. The receiving center will be located at either a current facility owned by SCL Saint James Hospital or will be built by CCCS on property it owns.

It's important to note that, *apart from Gallatin County*⁶⁶, every county/provider in Montana in the process of developing crisis centers plan to limit admissions to people who voluntarily agree to services – thus limiting drop off services by law enforcement, first responders and Mobile Crisis. This approach to serving people based on definition versus acuity conflicts with the Crisis Now “open door” model and best practices. That is, it subverts an underlining function of crisis centers: diverting people from hospitals and (potentially) jails to more appropriate (ideally less expensive, better equipped) care offered by crisis centers. For systemic adoption of the Crisis Now model and evidence-based practices in crisis services, we strongly recommend Montana revise licensing of Crisis Receiving and Stabilization Centers to encourage and allow both voluntary and involuntary admissions and services within the same facility.

⁶⁵ Based on the facility assessment conducted by WICHE in May 2022, the Journey Home facility, which is owned by the County and built for the purpose of operating as a crisis receiving and stabilization center, has been vacant but has been well maintained by the County and therefore should require minimal capital repairs and improvements.

⁶⁶ Connections Healthcare Solutions is currently working with Montana state officials to change licensing rules to allow Crisis Receiving and Stabilization Centers provide both voluntary and involuntary urgent psychiatric care within the same crisis facility.

Projected Crisis Center Locations and Providers 2024: Based on known plans and activities (and providing financial resources for capital improvements and are sufficient to sustain operations -- including a professional and paraprofessional workforce), Montana may have as many as (11) behavioral health crisis centers operating by 2024.

Table #11: Projected Crisis Center Locations and Providers 2024

County	Receiving	Stabilization	Receiving & Stabilization
Butte-Silver Bow	Community Corrections and Counseling Svcs.	WMMHC's Hays Morris House	—
Flathead		WMMHCs Glacier House ⁶⁷	
Gallatin	—	WMMHC's Hope House ⁶⁸	Connection's Crisis Response Center
Lake	—	WMMHC's Polson Lake House	—
Lewis and Clark	—	—	Journey Home (Provider TBD)
Missoula	WMMHC and Providence Hospital	WMMHC's Dakota Place	—
Ravalli		WMMHC's West House	
Yellowstone	Community Crisis Center ⁶⁹	—	—

Hospitals in the Crisis Continuum of Care

Given the absence of crisis receiving and stabilization facilities in the state, and the scarcity of community-based behavioral health services, Montana's hospital emergency departments remain the De Facto crisis receiving and (for those patients who stay longer than 24 hours) stabilization centers. Per our conversation with Montana's Hospital Association (MHA) staff, MHA members -- including the Critical Access Hospitals -- are experiencing increasing demand for urgent/crisis behavioral health care. Finding solutions to address the healthcare needs of the communities they serve and increasing demands on emergency departments for behavioral health care is a priority for the Association and its' members.

To move urgent behavioral health care out of the emergency department to more appropriate settings, some hospitals in Montana are replicating the urgent behavioral health care model programs being adopted by hospitals across the country. Emergency Psychiatric Assessment, Treatment, and Healing (emPATH) units, and Psychiatric Emergency Services (PES) are two such models. Professionally staffed by behavioral health clinicians, nurses and doctors, PES and emPATH units provide short-term (ideally less than 24 hours) crisis intervention, behavioral health assessment and stabilization. Importantly, given they are hospital-based versus community-based

⁶⁷ WMMHC's Glacier House in Kalispell and West House in Ravalli are the only stabilization centers in Montana currently providing voluntary and involuntary placement.

⁶⁸ Once the Crisis Response Center in Bozeman is fully operational, Hope House may become a residential crisis respite (a step down from the Crisis Response Center or hospitalization) or a center for Intensive Outpatient Treatment.

⁶⁹ The Community Crisis Center does not provide crisis services for people referred/requiring involuntary treatment.

service programs, PES and emPATH units do not divert people from costly and unnecessary hospital utilization. Table #12 below offers a status snapshot of hospital-based behavioral health services in Montana’s most population dense counties.⁷⁰

Table #12: Hospital-based Behavioral Health Care: Planned and Operating

County	Hospital	emPATH/PES	Intensive Outpatient	Inpatient
Butte-Silver Bow	SCL St. James			⇒
Cascade	Benefis Health System		★	★
Flathead	Logan Flathead Regional Medical Ctr	⇒	⇒	⇒
Gallatin	Bozeman Health Deaconess	⇒		⇒
Lewis and Clark	St. Peter’s Health	⇒		★
	Shodair Children’s	⇒		★
Missoula	Providence St. Patrick’s			★
Yellowstone	St Vincent Healthcare			
	Billings Clinic	⇒		★

★ = Operating
⇒ = Actively Planning

Montana’s Critical Access Hospitals: Critical Access Hospitals (CAH) are another key component of Montana’s healthcare and hospital system. Critical Access Hospitals are designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare *by keeping essential services in rural communities*. Per CMS, CAH’s must meet the following conditions:

- Be in a rural area or an area treated as rural.
- Be located either more than 35-miles from the nearest hospital or CAH, or more than 15 miles in areas with mountainous terrain or only secondary roads.
- Maintain an annual average length of stay of 96 hours or less for acute care patients.
- Provide 24/7 emergency care services.
- Maintain no more than 25 inpatient beds.

In addition to the 25 inpatient beds, *a CAH may also operate a psychiatric and/or a rehabilitation unit* of up to 10 beds each. Therefore, by having designated psychiatric beds, the CAHs may be a potential alternative to stand-alone crisis receiving/stabilization centers for rural and frontier regions. However, the capacity for the CAH’s to provide those services is impeded by two major hurdles: 1) statewide shortage of licensed behavioral health practitioners and psychiatrists⁷¹; and 2) a lack of transportation options to help patients return to their homes and communities once stabilized and discharged.

Currently, there are 49 CMS designated CAHs in Montana. If the CAH’s become a component of crisis receiving/stabilization system, transportation will be an important barrier to resolve. As

⁷⁰ Although WICHE-BHP’s assessment focused on adult crisis services, given its inpatient pediatric behavioral health services, Shodair Children’s Hospital is listed. Additionally, Shodair is partnering with St Peter’s Health to plan and operate emPATH units for children and adults which will be located on Sodiari’s hospital property in Helena; provided agreements are finalized and construction is completed, the emPATH units may open in 2024.

⁷¹ Currently there is one (1) psychiatrist serving all of eastern Montana.

reported by hospitals, law enforcement agencies, providers, and advocates, it is common practice for police and sheriffs to transport people experiencing behavioral health crisis to hospital emergency departments. However, law enforcement is not a valid or appropriate resource for transporting individuals back to their homes and communities upon discharge. Therefore, without transportation resources, behavioral health patients in the CAHs could wait for hours and even days for transportation home or to more acute levels of care. As a result, the CAH's patient flow, staffing, and ability to comply with CMS requirements and limitations would be negatively impacted.

Given the mounting pressure put upon Montana's hospital systems as well as their continuing investment in urgent behavioral health care services, it behooves DPHHS/BHDD to include MHA and hospital leaders in the state's planning, development, and implementation of behavioral health crisis programs.

Montana's Federally Qualified Health Centers (FQHCs): An important shift occurred in community health when Federally Qualified Health Centers (FQHC) integrated behavioral health care into their clinics and practices: access to diagnostic services, medications, and treatment for millions of people who might not otherwise use the services of a Community Mental Health Center (CMHC). However, although the FQHC's integrated (i.e., behavioral and primary health care) services positively impacted access to care, it did not replace the CMHC's crucial function as the mental health safety net -- especially for those with serious and persistent mental illness.

There are 58 FQHCs in Montana which, individually and collectively, play a pivotal role in the delivery of community behavioral health services. With reported downsizing and closure of the CMHC's services in Montana, the FQHCs appear to be expanding their behavioral health services, including operating (or planning to operate) crisis services.⁷² Their involvement and leadership in improving access to urgent behavioral health care, including crisis receiving/stabilization centers and mobile crisis teams, is impressive. Examples of the FQHC's leadership and investment in crisis services include:

- Alluvion Health's operation of Mobile Crisis for Cascade County.
- Community Health Partners' partnership with Connections Health Solutions to operate the Gallatin County's Mobile Crisis Services.
- Greater Valley Community Health Center's plans to support and/or operate a Crisis Receiving Center in Kalispell.

DPHHS/BHDD is currently preparing an Administrative Rule change regarding crisis receiving and stabilization centers and programs. As of this report, FQHCs are not included in the proposed policy as approved providers for crisis receiving and stabilization centers. However, given the FQHC's leadership in the development of crisis services, we strongly encourage DPHHS/BHDD:

- 1) add FQHCs to the qualified provider list; and

⁷² Two examples: Alluvion Health, Cascade County's FQHC, is operating the County's Mobile Crisis program, and Greater Valley Health Center, Flathead County's FQHC, is considering starting up/operating that County's Crisis Stabilization Center.

2) given the FQHCs provisions of behavioral health services and now, increasingly, crisis services, review and establish accountability standards, quality measures, and reporting requirements equal to those of the CMHC's, including required services for people with serious and persistent mental illness.

Policies for Crisis Receiving and Stabilization Centers

Meeting Minimum Expectations. In 2020, the National Association of State Mental Health Program Directors (NASMHPD) adopted the “NASMHPD National Guidelines for Crisis Care”. The Guidelines include a review of “minimum expectations and best practices to operate a crisis receiving and stabilization services,” as previously outlined and shown below.

We strongly recommend DHHS/BHDD as well as counties require facility provider(s) meet these minimum National Guidelines' expectations and best practices.

NASMHPD Minimum Expectations and Best Practices for Crisis Receiving and Stabilization

Expectations and Best Practices	
Operations	<ul style="list-style-type: none"> ✓ Operate 24/7 365 days a year. ✓ Include beds within a real-time regional bed registry system to support efficient connection to needed resources.
Intake	<ul style="list-style-type: none"> ✓ Offers walk-in and separate first responder drop-off options. ✓ Offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders. ✓ Does not require medical clearance prior to admission; provides assessment and support for medical stability while in the program
Staffing	<ul style="list-style-type: none"> ✓ 24/7 multidisciplinary team able to meet needs of individuals experiencing all levels of crisis. ✓ Includes psychiatrists or psychiatric nurse practitioners, nurses, licensed/credentialed clinicians, peers with lived experience.
Services	<ul style="list-style-type: none"> ✓ Addresses mental health and substance use crisis issues. ✓ Assesses physical health needs and deliver care for most minor physical health challenges with an identified pathway to transfer the individual to more medically staffed services if needed. ✓ Screen for suicide risk and violence risk and, when clinically indicated, complete comprehensive suicide risk and/or violence risk assessments and planning. ✓ Incorporate some form of intensive support beds into a partner program (within the services' own program or with another provider) to support flow for individuals who need additional support. ✓ Coordinate connection to ongoing care.

Policies for Crisis Receiving and Stabilization Centers. DPHHS has proposed amendments to ARM 37.88.101 to update the BHDD Medicaid Manual to include a separate policy “for Crisis Receiving Program to better align with the *Crisis Now* model” defined as “community-based crisis facilities (programs)”; the proposal outlines DPHHS/BHDDs plans to implement a tiered funding model: 1) Tier I: Crisis Receiving Program; 2) Tier II: Crisis Stabilization Program; and 3) Tier III: Crisis Receiving and Stabilization Program.

WICHE-BHP reviewed the draft policy (#450/451) and submitted recommendations per public comment requirements to DPPHS/BHDD. Chief among our recommendations was a change to the “Provider Requirements” and the addition of Key Performance Indicators:

Approved Providers: Currently, approved providers for Crisis Receiving and Stabilization Programs include licensed hospitals or licensed Mental Health Centers (MHC); WICHE-BHP recommended adding FQHCs and, if they come to fruition, Certified Community Behavioral Health Clinics (CCBHCs) as approved providers.

Performance Measures and Expected Outcomes: Based on research of performance measures specific to crisis receiving/stabilization centers (sometimes referred to as Behavioral Health Urgent Care) adopted by other states, we recommended DPHHS consider adding policies and expected outcomes similar to North Carolina's Division of Mental Health, as outlined below.⁷³

- a) Individuals will be triaged, and a level of urgency will be determined within 15 minutes of entering the Crisis Receiving and/or Stabilization Program
- b) Individuals will receive services and support at the Crisis Receiving and/or Stabilization Program that reduces the potential Emergency Department admission.
- c) Individuals will be linked to clinically appropriate community-based services to decrease the recurrence of crisis.
- d) Individuals will be linked to a higher level of care when clinically indicated.
- e) At least 75% of members seen will receive the full crisis assessment which will include – at a minimum – initial screening for health and safety, assessment by a nurse for any potential medical concerns, assessment by a licensed clinician and/or psychiatrist that includes assessment of safety to return to a community setting, and intervention detailed in the service definition.
- f) Some members may need diversion to emergency medical attention or leave Against Medical Advice (AMA), but this should be the exception.
- g) Crisis Stabilization staff will attempt to follow up with 100% of individuals discharged into the community via phone within five (5) calendar days of the service ending.

⁷³ NC Division of Mental Health, State-Funded Behavioral Health Urgent Care Developmental Disabilities & (BHUC) Substance Abuse Services Policy, 2/1/2020; State Funded Behavioral Health Urgent Care BHUC effective 2... | NCDHHS

FUNDING CRISIS PROGRAMS AND SERVICES

As described by DPPHS/BHDD's in its 2022 strategic plan, "Montana's behavioral health crisis response and stabilization services have historically been funded through an inefficient combination of state general fund, Medicaid, and local community dollars." In our opinion, DPPHS/BHDD's efforts to resolve funding inefficiencies via grants, fee-for-service funding, and tiered as well as bundled Medicaid rates are critical steps toward elevating and simplifying the state's funding strategy for system development.

Governor Greg Gianforte's HEART (Healing and Ending Addiction through Recovery and Treatment) initiative proposes leveraging approximately \$6 million in new revenue from marijuana taxes to increase Montana's federal Medicaid revenue. Per H.B.701, HEART will invest "significant state and federal funding to expand the state's behavioral health continuum" including prevention and early identification of behavioral health issues and monitoring for quality of care. HEART funds may be instrumental in the operation and sustainability of Montana's crisis services.

Cross-System Impact and Savings: The cost of implementing mobile crisis and a crisis continuum of care overall is significant. Cost saving can be equally significant. By diverting individuals in crisis from more intense and costly levels of care like psychiatric inpatient hospitalization, emergency departments, and criminal justice systems, state and local public agencies experience multi-systemic cost savings.⁷⁴ For example:

- ➔ In 2019, out of nearly 24,000 calls to Portland Oregon's mobile crisis CAHOOTS (i.e., Crisis Assistance Helping Out On The Streets), the Team *requested police backup only 150 times, or less than 1%*⁷⁵. Notably, the CAHOOTS model is replicated in communities across the country, including in Missoula, Montana.
- ➔ One study found that MCT intervention *increased likelihood of use of community mental health services in 90-day follow-up by 17%, compared to hospital-based emergency services*⁷⁶. It should be noted that the teams surveyed were comprised of two behavioral health clinicians, which reflects the *Crisis Now Model*. Furthermore, *those who received emergency department services were 1.5 times more likely to be hospitalized in 30-day follow-up period*.
- ➔ Citing cost savings and improved quality of life, the City of Missoula's preliminary 2023 budget proposes \$736,461 for the community's Mobile Support Team. Mayor John Engen justifies the proposed budget in a letter to the community in which he wrote: "*This fiscal year, this team has responded to 1,677 calls for help. MST has been involved in 398 diversions from the hospital Emergency Departments, an average cost savings of \$2,050 per visit, along with 52 diversions from jail when no crimes have been committed and there is a known mental health issue....*"⁷⁷

⁷⁴ National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit
<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

⁷⁵ <https://whitebirdclinic.org/what-is-cahoots/>

⁷⁶ Dyches, et al. (2002). The Impact of mobile crisis services on the use of community-based mental health services. *Research on Social Work Practice*. 12(6). Doi: 10.1177/104973102237470

⁷⁷ City of Missoula Mayor Engen Budget letter 2023, June 29, 2022; [Memorandum \(missoula.mt.us\)](https://www.missoula.mt.us/DocumentCenter/View/11111/Memorandum)

In addition to highlighting the dramatic impact crisis services can make across systems, the City of Missoula’s proposed budget and Mayor Engen’s letter suggests that public funding may be stronger for crisis services operated by first responder organizations, such as fire departments, by being funded, in part, by public safety/emergency response funds and/or tax revenue.

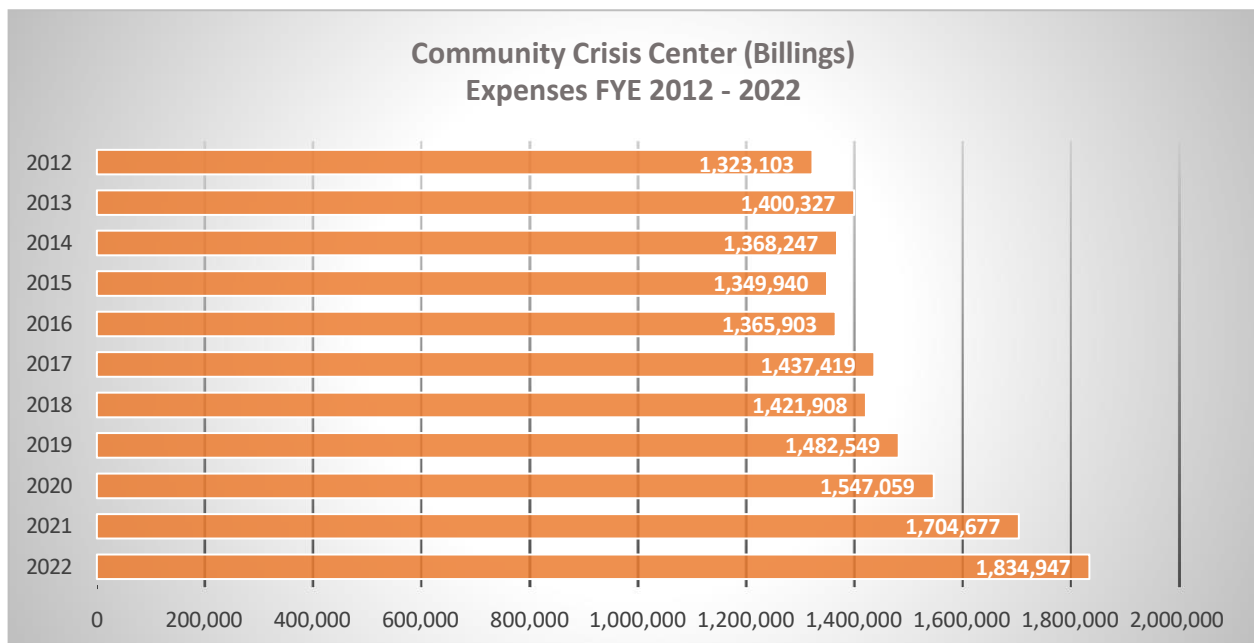
Cost of Operating Crisis Services. Operating and sustaining the *Crisis Now* model is an expensive undertaking requiring substantial commitment of both funding and workforce resources to sustain operations. In fact, two organizations in Montana that have operated crisis services and intend to operate per the *Crisis Now MCT* model have reported projected annual operating expense of nearly one million (\$1M) dollars. Given the staffing requirements and 24/7/375 operations their projections are, from our perspective, realistic.

Operating crisis receiving and stabilization centers are more expensive than operating MCTs -- especially when Crisis Now standards are adopted. The “best case/worst care” income scenarios shown below was recently drafted by a local planning coordinator for a proposed crisis receiving center in Montana; note the projections assume the center will receive the maximum Medicaid and State daily (i.e., bundled) funding rate of \$363.95.

<u>Crisis Receiving Center: Income Projections</u>	
Annual Operating Expense (annual)	\$1,750,000
<i>Best Case Scenario: Operating @ 100% Capacity (i.e., “beds full”)</i>	
State Daily Reimbursement (\$363.95 x 13 people per day)	\$1,726,942
County Mental Health Mill Levy Funds (if passed)	<u>\$ 125,000</u>
Balance: Funds Available, Year-end	\$ 101,924
<i>Medium Case Scenario: Operating @ 75% Capacity</i>	
State Daily Reimbursement (\$363.95 x 10 people a day)	\$ 1,328,487
Money from County Mental Health Mill Levy Funds	<u>\$ 125,000</u>
Balance: (Gap to be filled)	\$ [296,582]
<i>Worst Case scenario: Operating at < 50% Capacity</i>	
State Daily Reimbursement (\$363.95 x 6 people per day)	\$ 797,050
County Mental Health Mill Levy Funds	<u>\$ 125,000</u>
Balance: (Gap to be filled)	\$ [827,950]

The projections demonstrate the tenuous financial position of a crisis receiving center. For example, in order to have a potential surplus at year-end, the receiving center must operate at 100% capacity *and* the center must receive added public funding (in this case mill levy is proposed) – otherwise the organization will have significant annual budget shortfalls.

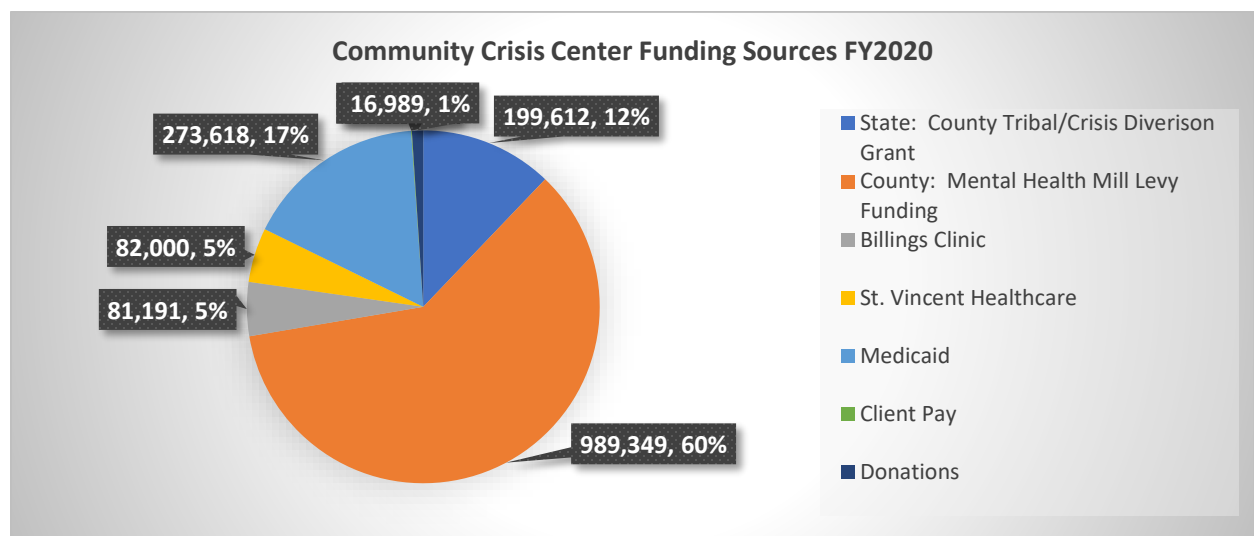
Operational costs of the longest running (and only) crisis receiving center in Montana, the Community Crisis Center, offers additional insight into the cost of operating a crisis center.⁷⁸



Providers, counties, and the state can assume the cost of operating crisis services will increase year over year. Further, stabilization services have the added expense of longer length of stay.

Funding Crisis Receiving and Stabilization Centers

The Community Crisis Center also offers a realistic perspective on the need to blend and diversify funding sources to operate and sustain 24/7/365 services. As reflected by their 2020 income sources, Medicaid, county-level (mill levy) funding, hospital funding, and state grants substantially support the CCC's operations.



⁷⁸ The Community Crisis Center in Billings does not have licensed psychiatric personnel on staff, per the Crisis Now model. Therefore, the expenses reflected may be low compared to minimal staffing guidelines of the Crisis Now model.

Notes re CCCs Income Sources:

- Mill Levy Funding: Up until 2020, CCC received \$900,000 in mill levy funds. However, the mill levy funding has “become a collaborative RFP grant process” in which other crisis services providers received funding in Yellowstone County. Consequently, the CCC has experienced a gradual decrease in Mill Levy funding: from \$700,000 in 2021, to \$558,000 in 2022, and (projected) \$312,000 in 2023. As the decreases have occurred, the CCC has spent down its reserves; therefore, the impact of the Mill Levy funding decrease is yet to be known.
- Crisis Diversion Grants (CDG): Historically, CCC received up to \$350,000 annually to support operations via CDG funds (formerly called “County Tribal Matching Grants). In 2020, BHDD changed the CDG funding strategy to “a collaborative community process” to support crisis system planning as well as the development and operation of mobile crisis programs across the state; as a result, in 2021, CDG funding for the CCC decreased to approximately \$262,000.

As providers assess operating costs and planners prepare budgets for crisis services, their greatest funding challenge arises from reliance, in great part, on billable care and reimbursement for their services; the majority of which are people covered by Medicaid or presumptive Medicaid eligibility. However, the operation of crisis services requires 24/7/365 staffing -- regardless of the number of people needing those services at any point in time. For example, a Mobile Crisis Team may be dispatched to three or four calls one day, and 10 to 20 calls the next. This unpredictable utilization factor also applies to Crisis Receiving and Stabilization Centers. For example, the capacity of the Crisis Receiving Center may be 16 people a day, but the number of people served in a day (i.e., daily census) could be as few as five. Yet, regardless of the number of people served each day at the Crisis Center, funding must sustain staffing requirements to handle full capacity and utilization.

All to say, providers must staff for full coverage regardless of daily utilization. Yet if the number of people served each day is inconsistent and unpredictable (which in crisis services it will not be), even at the highest reimbursement rates, Medicaid funds will not cover 24/7/365 operating expenses.

Funding Sources

Per BHDDs staff experience in managing grants, funding streams and utilization, as well as in supporting grantees and providers, DPHHS/BHDD’s funding configuration created “spending, messaging, and managing inefficiencies that result in insufficient crisis system utilization and outcome reporting and unmet needs within communities.” To address those challenges and build efficiencies, BHDD staff proposed and gained approval to decrease the number of fund types (or “buckets”) from seven (7) categories to three (3).

Funding for Diversion and Crisis Services: *FY21/22 Reflected*
Total (not including Medicaid dollars): \$4.9 Million

Type	Purpose	Source(s)	Amount
1 Crisis Diversion Grants	Crisis intervention and jail-diversion programs	State General Fund; CMS Transformative Transfer Initiative Grant; Mental Health Block Grant; Substance Abuse Block Grants	\$3,165 M
2 72-hour Funds	Crisis stabilization services up to 72 hours for non-Medicaid adult	State General Fund	\$400K
3 14-day Diversion Funds	Crisis stabilization services up to 14 days for non-Medicaid adults requiring commitment in a safe environment as alternative to jail or MT State Hospital.	State General Fund	\$150K
4 Emergency Detention Crisis Beds	Short-term secure inpatient care during involuntary commitment petitions	State General Fund	\$400K
5 Mental Health Services Plan	Services for non-Medicaid adults with serious persistent mental illness, including those in detention centers.	State General Fund	\$100K
6 Goal 189	Services for “specialized population” discharged from MSH or at risk for admission to MSH.	State General Fund	\$1 Million
7 HEART Initiative jail-based grants	Behavioral health services provided in detention centers.	HEART Revenue	\$1.1 M

Effective for biennial years 2022 – 2024, Montana’s state and Medicaid funding for crisis services will fall within four three (versus seven) buckets, as reflected in the table below.

Funding for Diversion and Crisis Services: *Effective 2022 -2024*
Total (not including Medicaid dollars): \$3,850,000+

Type	Purpose	Source	Amount
1 Crisis Diversion Grants	Crisis intervention and jail-diversion programs	State General Fund; HEART Revenue; HEART Jail-based Grants; Mental Health Services Plan/State General Fund; Goal 189/State General Fund; Mental Health and Substance Abuse Block Grants.	\$3.7 M
2 Non-Medicaid Crisis Program	Crisis services (assessment, mobile crisis, stabilization) for non-Medicaid adults.	State General Fund	\$150K
3 Medicaid Crisis Program	Crisis services (assessment, mobile crisis, stabilization) for Medicaid-covered adults.	TBD	TBD

Streamlining the funding mechanisms and administration can stimulate the growth and expansion of crisis services by reducing the burden of applying for and managing multiple planning, implementation, and expansion grants. Additionally, funding changes may also be a mechanism for DPHHS/BHDD to support demonstration or pilot programs and/or incentives for regional crisis programs. Finally, by “braiding” funds the state may be able to help fund crisis services provided to non-Medicaid and uninsured patients in equal measure to the crisis services covered/funded for Medicaid recipients – a system improvement goal referred to by BHDD leadership as “mirrored funding.”

Medicaid: Given the providers’ as well as the state’s reliance on Medicaid funding, flexible and adequate Medicaid funding is a critical tool in the ongoing development and implementation of crisis services. Being flexible entails embracing alternative payment models (e.g., bundled rates) for the array of crisis services. Adequate Medicaid funding includes reimbursement rates that cover the cost-of-service provision and are updated on a regular basis. DPHHS’s recent provider rate study and BHDD’s proposal for tiered and bundled rates are two important steps toward building flexible and adequate funding streams.

Providers must staff for full coverage 24/7/365 regardless of daily utilization. Yet if the number of people served each day is inconsistent and unpredictable, even at the highest reimbursement rates, Medicaid funds will not cover 24/7/365 operating expenses.

Provider Rates: In September 2021, DPHHS committed American Rescue Plan Act (ARPA) funds to conduct a detailed provider rate study for home and community-based services. In addition, a study of broad programmatic rates was authorized through state legislation. The State of Montana contracted with Guidehouse to conduct the study. The results of the study were made available to the Interim Committee Children, Families, Health, and Human Services.

In an effort to maintain critical core services, State legislation recommended conducting a provider cost and wage survey, as well as gathering and analyzing broad program data, to determine if rates should be adjusted, including for behavioral health services.⁸⁰ It is anticipated that determining the true cost of providing care to those Montanans experiencing a behavioral health crisis and adjusting or modifying Medicaid rates accordingly will increase the likelihood that a comprehensive array of crisis services (i.e., call center, mobile crisis, crisis receiving/stabilization, and follow-up/aftercare services) will be developed and sustained.

In addition, DPHHS/BHDD has proposed a new Rule (Rule 5) that “will align Medicaid and non-Medicaid mental health services among recipients and allow the state to establish a comprehensive continuum of care to address Montana’s behavioral health needs.” The proposed Rule makes “substantive changes” to the BHDD Non-Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health by adding non-Medicaid mental health services

⁸⁰ Additionally, the survey/study included provider rates for intellectual and developmental disabilities, long term services, and other support programs; the legislation also focused on quantifying the impact COVID 19 had on these services.

to the Manual. According to DPPHS/BHDD, the proposed changes are a reasonable necessity and “represent alignment with the mental health services provided to Medicaid members.” This strategy is referred to by BHDD leadership as “mirrored funding”. If the Rule change is approved, DPPHS’s rate for non-Medicaid patients will mirror the new Medicaid bundled reimbursement rate of \$363.95.

ARPA-enhanced Medicaid Funding for Mobile Crisis: Effective April 2022, new provisions in the American Rescue Plan Act (ARPA) allow for increased Medicaid reimbursement for “qualifying community-based mobile crisis intervention services”. The revision provides up to five (5) years of additional funding to states for mobile crisis services for Medicaid eligible individuals, either through the state plan or through a waiver of the state plan. Per DPPHS/BHDD, the new provision “... complement the resources available through the MHBG [Mental Health Block Grant] and existing CCBHCs [Certified Community Behavioral Health Clinics] to enable more robust support crisis intervention and management services.”

To prepare for the new rates, in July 2022, DPPHS/BHDD submitted an Administrative Rule change expanding allowable provider types to bill for Medicaid reimbursed mobile crisis services. Expected to be in effect January 1, 2023, the change will allow both historically approved providers (i.e., hospitals and behavioral health providers) and other community service entities, such as fire departments, to bill Medicaid.⁸²

To qualify for the highest rate, DPPHS/BHDD will require the mobile team’s staffing is sufficient to cover 24/7/365 coverage. Further, the team composition must include (in addition to the mobile crisis team responders) a program manager and a care coordinator. As noted in the “Mobile Crisis Teams” section of this report, currently none of the mobile crisis teams in Montana meet the CMS/ARPA funding criteria for the highest reimbursable rate.

HEART: Healing and Ending Addiction through Recovery and Treatment: As previously noted, Montana’s HEART Initiative is projected to invest “significant state and federal funding to expand the state’s behavioral health continuum” to:

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

As a result of the HEART Initiative and its potential to impact funding for Montana’s behavioral health services, DPPHS has submitted a Section 1115 Demonstration Waiver to CMS “to build upon the strides made by the state over the last decade to establish a comprehensive continuum

⁸² CPT codes for crisis psychotherapy were added to the non-Medicaid fee schedule October 1, 2022 and are open to licensed clinicians providing services within their scope of practice. Individual clinicians would have been able to bill Medicaid prior to that date.

of behavioral health—mental health and substance use disorder (SUD)—services for its Medicaid members.” Further, per House Bill 701 (HB 701) and projected revenue generated by taxation of marijuana sales, the legislature “appropriated [funds] for each year of the 2023 biennium to the department of public health and human services for eligible services and programs in accordance with the HEART fund...[include]:

- \$6 million in state special revenue funds; and
- \$19 million in federal special revenue funds.”

The intent of the legislature was “that these appropriation amounts be included as part of the base budget for the department of public health and human services for the biennium beginning July 1, 2023.”

As a new and substantial source of funding, the HEART Initiative and 1115 Waiver can positively impact Montana’s behavioral health crisis and diversion programs, especially for Montanans with substance use disorders and/or serious and persistent mental illness. Based on our interviews with stakeholders and the intended goals of the Initiative, we assume DPHHS/BHDD, providers, and advocates will actively track the utilization and impact of the HEART/HB-701 funds.

Mobile Crisis Grants – HB 660: In 2019, Montana legislature passed House Bill (HB) 660 to establish funding for mobile crisis units. Overseen by DPPHS/BHDD, the funds provided local community grants capped at \$125,000 each; a dollar-for-dollar local government match (which could be a “soft”/in-kind match) was required. Importantly, this was a one-time appropriation of \$500,000 reserved for the biennium July 1, 2019 - June 30, 2021.

We mention the HB-660 Mobile Crisis Grants as they sparked the launch of Gallatin, Lewis and Clark, and Missoula Counties’ mobile crisis services. Today, Crisis Diversion Grants (CDG) are the primary state funding source to support planning and start-up of mobile crisis services in Montana.

Crisis Diversion Grants (CDG): Formerly named, “County Tribal Matching Grants” DPHHS/BHDD Crisis Diversion Grants (CDG) provides funding to counties and tribal governments to support planning, launch, operation, and development of crisis services.⁸³ The CDG program is an appropriation by the Montana legislature to fund counties and federally recognized tribes to:

- A. Align Montana’s crisis system with *national best practices*;
- B. *Reduce reliance on the Montana State Hospital* for emergency and court ordered detention and evaluation;
- C. Support the *treatment of mental illness closer to home by increasing local treatment capacity* and creating better treatment outcomes;
- D. *Increase the number of intervention and jail diversion options* that provide judges, county attorneys, and law enforcement with alternatives to incarceration; and
- E. Establish and support *collaboration* among community stakeholders to address community needs.

⁸³ Notably, only one Montana Tribe has applied for and received a CDG: Blackfeet Tribe. The Tribe was awarded \$111,101 for fiscal years 2021 – halfway through 2023 to support their crisis planning and intervention initiatives.

The funding is authorized by MCA 53-21-1203 and ARMs 37.89.1001 - 37.89.1009., providing \$4,650,000 over the biennium.⁸⁴

Projects and services that currently qualify for CDGs funds include infrastructure, crisis staff, jail-based services, Crisis Intervention Training (CIT), community crisis planning, and mobile crisis teams. Behavioral health assessments, services, and case management for individuals who are not Medicaid eligible also qualify for funding. Notably, the CDG has also been a major source of funding to support operations of the Community Crisis Center in Billings.

Changes to CDG Funding for Mobile Crisis. The CDG is a tiered-funding model in which the funding counties and tribes may apply for is based on their stage of programmatic and/or system development. Up to this point, the CDG has provided planning and operational support for all seven of Montana's currently operating mobile crisis programs.

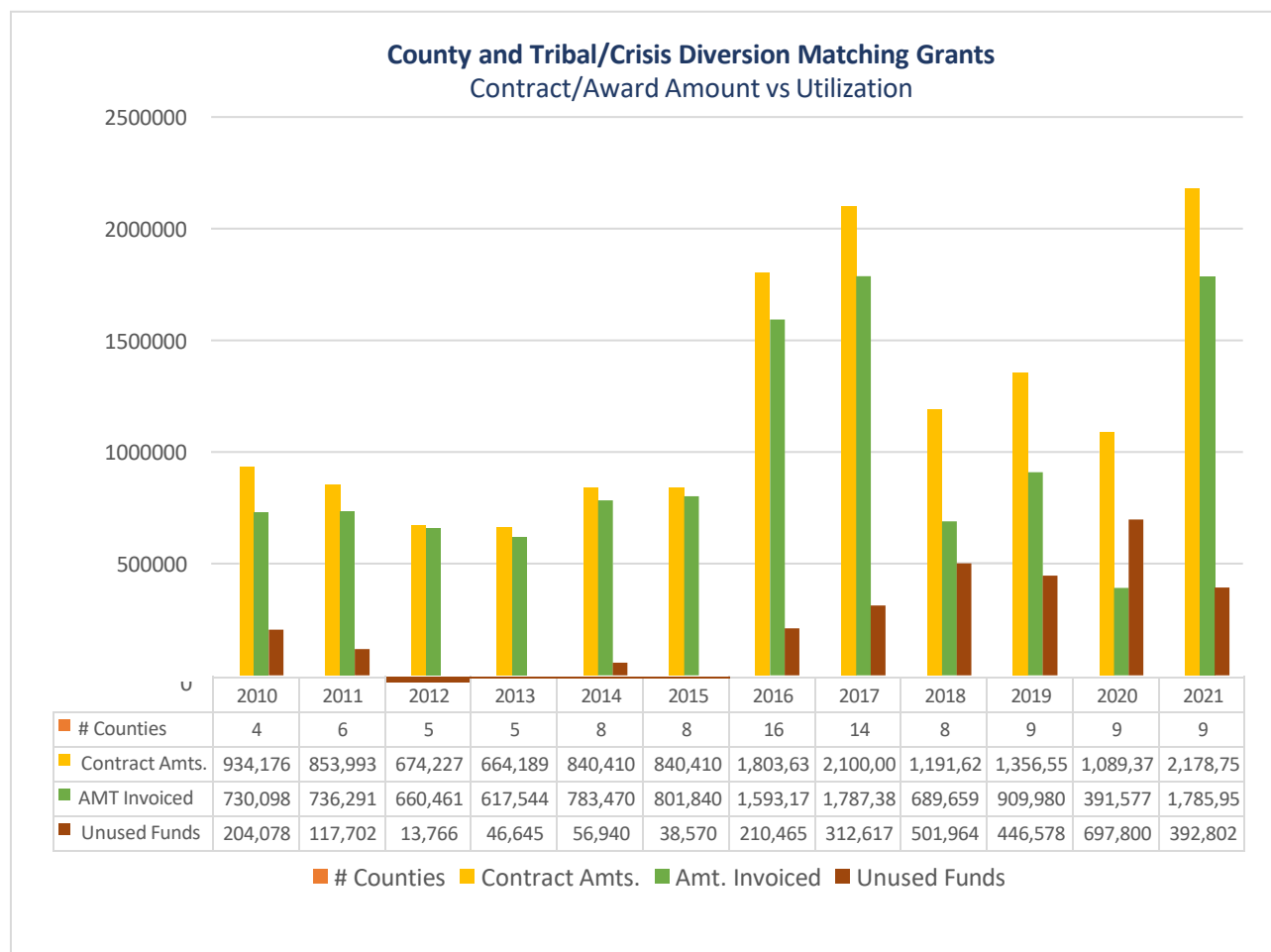
As part of the State Plan, mobile crisis providers will bill Medicaid for mobile crisis services and the CDG funds will no longer be utilized to support mobile crisis service operations. The change in funding sources could affect the mobile crisis providers who are justifiably concerned Medicaid billing will not cover the cost of operations.

In order to for providers to receive the full benefit of Medicaid reimbursed services for mobile crisis, DPHHS/BHDD will quite likely need to train and provide technical assistance to providers on Medicaid coding and billing practices.

CDG Funding Appropriation and Utilization. With some fluctuations, since 2010 the amount of funding available to county and tribal governments has increased 133% -- from \$934,176 in 2010 to \$2,179,753 in 2021. As reflected in the table below, the number of county and tribal governments that received funds peaked in 2016 when 16 counties received CDG funding -- up from four (4) in 2010 when the program began and nine (9) in the most recent year ending, 2021.

Interestingly, since the inception of the County Tribal/Crisis Diversion Grants in 2010, the amount of funds awarded to county and tribal governments (per their proposals) has never been fully expended (or invoiced). In fact, from 2015 thru 2018 (four years), the combined total of funds not invoiced by the governments was \$1,088,203. Further, the amount of funds not invoiced from 2019 – 2021 totaled \$1,537,180. However, due to the impact of the pandemic (i.e., service closures, delays in projects, etc.) we consider those years to be outliers when assessing funding appropriation and utilization.

⁸⁴ CTMG RFP FY22-23 Informational Call Slides (mt.gov)



Given the pattern of unused Crisis Diversion Grant funds allocated year after year, it is recommended DPHHS/BHDD consider increasing allocation of CDG funds for start-up and operating costs of crisis receiving and stabilization centers. Per our recommendation regarding regionalization, a portion of CDG funds could also be allocated for multi-county or regional demonstration sites for mobile crisis and/or crisis receiving and stabilization services. Incentive funding, in which counties/providers are given “bonus” payments tied to quality standards and Key Performance Indicators established by BHDD, is another option to consider.

The goal of CDG funding is to *“Support crisis intervention and jail diversion efforts that prevent unnecessary restrictive placements such as incarceration, hospitalization or commitments to the Montana State Hospital.”* The progress and achievements of local communities point to the fact that CDG funds have facilitated important system advancements across the state and at all stages of program development – from planning and start-up of crisis intervention and jail diversion programs, to adoption and/or modifications to the *Crisis Now* model.

Local Funding: Mill Levies. Mill levies for mental health is a common strategy for funding jail diversion and crisis prevention, intervention, and stabilization programs in the United States. Mill levies also support behavioral health jail diversion and crisis services in Montana, for example:

- Cascade County’s Mobile Response Team is partially funded with the County’s Mental Health Mill Levy.

- Yellowstone County’s Mental Health Mill Levy provides funding for a range of crisis prevention, intervention, and stabilization services, including the Community Crisis Center⁸⁶.
- Lewis and Clark has the Jail Diversion and Risk Prevention Levy for “Early Intervention, Mental Health, Pretrial Services, a Volunteer Programs Coordinator, and Stability Funding.”
- Missoula is bringing a vote to its citizens for a new mill levy; if passed, a portion will be designated for their Mobile Crisis program as well as (future) crisis receiving center.

Montana’s Hospital’s Support and Investment: Montana’s hospitals are playing an instrumental role in the delivery and funding of crisis services. For example, **Bozeman Health Deaconess** has entered a contract with a nationally recognized provider of crisis care, Connections Health Solutions, to operate a Crisis Receiving and Stabilization, **SCL St. James Hospital** in Butte-Silver Bow has announced it will provide a facility to Community Corrections and Counseling Services for a crisis receiving center, **Saint Peter’s Health** in Lewis and Clark is operating the mobile crisis team, and finally, **Providence Saint Patrick’s Hospital** is considering a partnership with Western Montana Mental Health Center to operate a crisis receiving center.

The hospitals’ substantial investment in the Community Crisis [Receiving] Center (CCC) in Billings is another example. Since its opening, **Billings Health and Providence St Vincent’s** hospitals have provided in-kind human resources, IT, food, and laundry service to the CCC. As an example of the hospitals’ in-kind support, from screening applicants to managing employee benefits, the hospitals assist CCC with all aspects related to human resource management. In addition, as shown in the table below, all CCC staff are either employees of Billings Clinic or St. Vincent’s.

<i>CCC Billings Clinic Employees</i>	<i>CCC St Vincent Employees</i>
→ 1 FTE Director	→ .5 FTE Assistant
→ 8 FTE Licensed Mental Health Clinicians	→ 2 FTE Licensed Addiction Counselors
→ 4 FTE MH Workers	→ 4.4 FTE Nurses, includes .5 FTE supervisor
→ 8 Per Diem MH Workers	→ 6 Per Diem Nurses (leave coverage)
→ 1.5 FTE Case Manager	

Notably, the CCC reimburses the hospitals for staff salaries and benefits. Still, the hospitals’ contributions of HR, IT, food, and laundry services are a significant cost saving for CCC’s operations.

Certified Community Behavioral Health Clinics (CCBHCs). Montana’s behavioral health providers are actively working with legislators and policy makers to secure the State’s and DPHHS’s endorsement of the Certified Community Behavioral Health Clinics (CCBHC) model. Importantly, endorsed/designated CCBHCs are required to provide a comprehensive range of mental health and substance use disorder services, including crisis services.

To date, two (2) of Montana’s Community Mental Health Centers (CMHCs) and one (1) behavioral health provider have received SAMSHA’s CCBHC “Planning, Development and Implementation” grants: Western Montana Mental Health Center, Many Rivers Whole Health (formerly, The Center

⁸⁶ Community members are now in the process of planning for a mobile crisis team for Yellowstone which, once up and running, will likely qualify for mill levy funds.

for Mental Health), and Rimrock. Each organization received \$4 million over a two-year period to develop systems, programs, and practices toward CCBHC implementation. In addition, according to key informants, three additional behavioral health providers/community mental health centers are applying for CCBHC Implementation grants.

We believe the adoption of CCBHCs can potentially result in a positive and major shift in Montana's behavioral health care continuum of care and funding mechanisms for crisis services. The substantial grants that organizations are receiving for CCBHC planning and implementation can be instrumental in the development of behavioral health crisis services and the continuum of behavioral health care in Montana. Further, once certified, the CCBHC's payment model will provide enhanced funding, equitable to FQHCs, for the CCBHCs to operate, sustain, and expand their services while elevating reporting, accountability, and quality expectations.⁸⁷

Clearly, Montana's providers will need to rely on a blend of funding to operate 24/7/365 quality crisis services. As the system grows, the need for funding will incrementally increase. If the CCBHC system change is approved by the Montana legislature (and CMS certifies CCBHC providers), and if CMS approves the 1115 Medicaid Demonstration Waiver, it is suggested that DPPHS conduct a fiscal analysis to forecast and strategically plan for State funding required to sustain a crisis continuum of care.

⁸⁷ As previously described in this report, *to retain certification and elevated funding, CCBHCs must adhere to elevated accountability practices including collection and reporting on encounter, clinical outcomes, and quality improvement data* which the state, in turn, must report to CMS. Additionally, states are required to submit annual assessment reports on the CCBHC demonstration program's impact, including: 1) access to community-based behavioral health services; and 2) quality and scope of services.

https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

DATA COLLECTION AND REPORTING

Data collection and utilization is essential for planning, launching, operating, evaluating and improving crisis services and systems. Data provides a snapshot of information that can be used to identify what is and is not occurring in a given location. Data analysis at a statewide level is a clear and consistent method to assess gaps across various parts of the service delivery system. Data shared between stakeholders is a powerful way to demonstrate and assess impact and resource utilization.

As discussed in our recommendations, as well as the sections of this report specific to Mobile Crisis Teams and Crisis Receiving and Stabilization Centers, Key Performance Indicators (KPI) establish standards of quality care, programmatic goals, and intended systemic outcomes. Those KPI's, in turn, inform data points and metrics for system reporting, problem solving, and improvements. Applying KPIs and data points across the continuum of crisis care is a resource and time intensive endeavor yet critical to the State's system of care and the allocation of resources.

The simplicity and applicability of data entry and retrieval for staff on the front line (i.e., the 988, MCT, and crisis center staff) will be instrumental to the success of DPHHS/BHDD data collection and reporting systems. It is important that all staff along the crisis continuum understand which data points are important to capture, as well as which are not, so they can make informed decisions during active crisis situations.⁸⁸ It is imperative that in each interaction within the crisis continuum, consumer outcome or disposition information should be recorded and reported to the appropriate oversight organization. Data points to be collected should be clearly outlined at the state level and crisis service staff must be trained in the same data collection standards and processes. Standardization and training will result in robust comparable data for state administrators, providers, and policy makers to analyze both the micro and macro aspects of the crisis service delivery system.

Having the ability to quickly and accurately access crisis episode data across providers and the continuum of care will enhance monitoring and compliance with state standards.⁸⁹ Examples of standard data to record across the crisis continuum (i.e., 911 and 988 call centers, mobile crisis response, crisis receiving and stabilization) include: ⁹⁰

- ➔ Any “critical incidents” that took place during the crisis service
- ➔ Any contact with first responders (i.e., EMS, paramedics)
- ➔ Any contact with law enforcement

⁸⁸ For example, overemphasis on gathering demographic information directly from the individual in crisis may be fruitless and result in little to no data-level understanding of the crisis episode. In fact, research and anecdotal evidence suggest demographic data is extremely difficult to collect during a crisis call or in-person response and is only successfully captured in about 50% of episodes.

⁸⁹ Colorado has been developing their crisis service continuum for over 15 years; for the past five years the state and providers assessed service utilization, efficiency, and improvement. In a presentation at NASMHPD's annual meeting, representatives of Colorado's crisis services identified several ongoing challenges re data reporting they are working to overcome. NASMHPD. September 2021. Using Data to Manage State and Local Level Mental Health Crisis Services. NASMHPD. September 2021. Using Data to Manage State and Local Level Mental Health Crisis Services, [Annual Meeting](#).

⁹⁰ NASMHPD. September 2021. Using Data to Manage State and Local Level Mental Health Crisis Services. [Annual Meeting](#).

- ➔ Any referrals to the emergency department
- ➔ Any admission to higher level of care and facility type (e.g., psychiatric bed, CSU)
- ➔ Decrease in suicide risk from initial contact to completion of service
- ➔ Where MCT is responding (e.g., school, home, jail, ED, local behavioral health provider)
- ➔ When MCT is not dispatched as a response for a crisis call

Importantly, capturing and analyzing outcome data will be key to DPHHS/BHDD's ability to identify service strengths and gaps. For example, if disposition data is showing a high percentage of individuals at crisis receiving centers being directly referred to a hospital emergency department, administrators and providers will want to investigate the motivating factors or cause and make adjustments to protocols, policies, and perhaps training.⁹¹

Legislative Reports: It will be important for DPHHS/BHDD ensure key data points that capture details of crisis episodes are recorded in a way that informs legislative-level decision-making. States with robust data collection systems suggested the following data points to aid in legislative understanding, including:

- Number of people served by each crisis service
- Ages of consumers
- Gender identity of consumers
- Percentage of crisis services that were delivered to special populations (i.e., Veterans, youth, individuals with intellectual and developmental disabilities)
- Number of new consumers, i.e., those experiencing their first crisis episode
- Number of frequent utilizers of crisis services; how often each received services in the last 30 days, 60 days, and 90 days

Data Reporting Dashboards: Data reporting dashboards track activity and utilization within a segment of the crisis system or across the continuum. The Mobile Crisis Response (MCR) Dashboards developed by Behavioral Health Link (BHL) provide an excellent visual of internal-facing dashboards.

Nationally recognized for their work in crisis service system development, Behavioral Health Link (BHL)⁹² is the State of Georgia's contracted provider for tracking and reporting on the statewide crisis service continuum of care.⁹³ For example, BHL's "Live Dashboard" and "Monthly Dashboard" track mobile crisis deployment and activities across the state. The dashboards include average response to dispatch time, number of dispatches, average response time, number of assessments completed, average assessment time, average linkage time, number of assessments sent to ED for medical clearance, and number of counties served. Some demographic information is also available, including client demographics, response location, disability type (if applicable), legal status (if applicable), and disposition by type.

⁹¹ NASMHPD (May 2022). Telling the Story: Data, Dashboards, and the Mental Health Crisis Continuum. [TA Coalition Webinar](#).

⁹² <https://www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/>

⁹³ <https://www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/>

Example: BHL's MCTs "Live" and Monthly Dashboards



BHL also operates the State's Bed Registry which, like the mobile crisis dashboard, can be filtered and sorted to provide regional and statewide service snapshots – an important operating factor to consider should Montana implement a multi-county or regional approach to crisis service access and delivery.

Data Collection and Reporting: Next Steps

Instituting a data collection and management system requires a high level of expertise. In addition to DPHHS/BHDD IT and data department, we strongly encourage the state to confer with the consulting firms currently assisting DPHHS/BHDD, each of which have expertise, experience and insight into the development, functionality, implementation, and/or utilization of behavioral health data collection, analysis, and systems: Alvarez and Marsal, JG Research Associates, and Loveland Consulting. In addition, it is recommended that DPHHS/BHDD engage key stakeholders to develop a plan at the state level for data collection and performance measurement across the crisis continuum.

Finally, if Montana's legislature moves to endorse CCBHCs, DPHHS/BHDD and the CCBHC providers, per CMS, must adhere to elevated data collection and reporting requirements. SAMHSA's Office of Management and Budget (OMB) created and made publicly available data reporting templates with standardized and straightforward data collection forms that capture 32 quality measures associated with CCBHCs.⁹⁴ It will be advantageous for DPHHS/BHDD to review OMB's templates and measures and adapt a similar system with standardized and straightforward data collection forms.

Service Registry Tool (Bed Board)

A Service Registry Tool (or Bed Board) is a critical tool to assure that people in need have access to appropriate available services. The benefit to individuals needing care is matched by the advantages seen by providers who can respond to a patient's needs efficiently and effectively -- resulting in improved care, better use of resources, and fewer errors⁹⁵. Further, Service Registries allow stakeholders to monitor waitlist numbers for bed-based services, identify challenges in placing individuals at appropriate levels of care, and identify different types of beds available at various facilities.

From a system perspective, a Service Registry can confirm gaps, identify barriers, and provide insight into service utilization and needs within the continuum of care. By providing real-time management of resources, the Registry can:

- ➔ Reduce time to connect clients to appropriate treatment
- ➔ Increase rates of diversion to appropriate levels of care
- ➔ Monitor bed capacity and utilization across the region in real-time and over time
- ➔ Increase provider responsiveness and ease of collaboration
- ➔ Increase client and provider satisfaction
- ➔ Decrease placement times and improves admission processes
- ➔ Reduce labor involved in facilitating placement

A severe shortage of services for acute psychiatric care nationwide has led SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD) to begin development on a registry of crisis intervention beds. Per SAMHSA, "Access to an accurate database of this kind will allow those managing serious mental illness (SMI) as well as people in crisis to navigate the

⁹⁴ <https://www.samhsa.gov/section-223/quality-measures>

⁹⁵ NASMHPD (May 2022). Telling the Story: Data, Dashboards, and the Mental Health Crisis Continuum. [TA Coalition Webinar](#).

crisis continuum and connect with adequate care seamlessly.”⁹⁶ Indeed, in the near future, state-driven psychiatric bed registries will be a primary tool used by emergency departments, psychiatrists, physicians, and local clinicians to quickly locate and contact facilities with available beds so that people in distress can gain access to services when urgently necessary. Per BHDD, statewide inclusion of acute inpatient beds within a real-time tool is required by 2024.

Recommendations from states who have implemented crisis bed registries.

NASMHPD and state administrators who have implemented crisis Bed Registries share the following recommendations: ⁹⁷

- Get buy-in from the hospital association and organizations within the public health system.
- Stakeholder engagement and buy-in are key components to a successful and sustainable system. Approach this as a stakeholder engagement project – not a technology project. Maintain early and frequent engagement with key stakeholders. Develop IT business and functionality requirements around stakeholder feedback, not vice-versa.
- Once the state has decided system requirements based on collaborative stakeholder conversations, identify a technology system or vender platform that meets needs and requirements; avoid committing to unnecessary functionality or features; don’t overcomplicate.
- The registry is a tool, not a solution. The suite of services within a full crisis continuum is the solution. The registry is a tool to navigate it.
- The most valuable assets for building and improving the system are those who use the system every day, i.e., clinical staff. Their input should inform updates and innovations as the systems develop over time.
- Most of the bed board/bed matching system projects take several years of collaborative planning and development.
- Test, test, and re-test before the system’s “go-live” date.
- This type of project requires frequent contact with clinical facilities and other agencies to train on how to navigate the bed registry, make referrals, and update bed availability.

⁹⁶ <https://www.samhsa.gov/newsroom/press-announcements/201901240130>

⁹⁷ NASMHPD (September 2021). State Implementation of Crisis Bed Registries with 988 and Behavioral Health Crisis Services. [Annual Conference](#).

Bed Registry Models⁹⁸

Bed registries offer various “system functions.” The following table is a snapshot of system functions that DPPHS/BHDD, in collaboration with stakeholders, may wish to investigate.

Type	States with Model	System Functions
Search Engines	CT, ID, MA, MI, NJ, NY, RI, UT, VT, OK, AL*, FL*, MD*, WV* (*Projected)	<ul style="list-style-type: none"> Authorized user visits website to view real-time bed data, including facility locations, contact information, and additional services User finds contact information and calls facility directly or intermediary (like a call center) to request a bed
Referral Systems	GA, NC, TN, VA	<ul style="list-style-type: none"> Authorized user visits private portal to view real-time bed data Users can submit HIPAA-compliant electronic referrals to secure a bed using preset forms and protocols Bed-based facilities can respond electronically Referral process and its disposition can be measured, documents, and monitored within the portal
Referral Networks	DE, IN, NE, NV, NM, OH	<ul style="list-style-type: none"> Authorized user visits private portal to view real-time bed data Users can submit HIPAA-compliant electronic referrals to secure a bed Bed-based facilities can respond electronically Users can facilitate referrals for behavioral health services to and from provider members of the referral network Referral process and its disposition can be measured, documents, and monitored within the portal

Recommendations: Finally, we offer the following recommendations for DPHHS/BHDD as it develops Montana’s bed registry/board:

- Conduct stakeholder surveys to determine what data is most important to report for a service registry, including level of care, location, and access to transportation.
- The system will develop over time, start with simple data points that can be easily reported.
- Determine who has control of the needed information, and their commitment to sharing data in real time.
- Determine whether there is a current state information system that could include a real-time service registry tool. If not, start with a basic system that can be easily accessed and updated.
- Consider using the same regions that are participating in the demonstration/pilot projects for the crisis care networks to implement a basic registry.
- Using the same advisory committees as in the demonstration/pilot projects, regularly review the system for ease of use, accuracy, and timeliness.
- Adapt and increase the scope as crisis care regions are added to the state system.
- This type of project will require DPHHS to have frequent contact with clinical facilities and other agencies to provide training on how to navigate the bed registry, make referrals, and update bed availability.

⁹⁸ NASMHPD (September 2021). State Implementation of Crisis Bed Registries with 988 and Behavioral Health Crisis Services. Annual Conference.

REGIONALIZING CRISIS SERVICES

Given Montana's population bases, geography, and workforce, it is impractical and not economically feasible to expect each county to have the full array of services in the crisis continuum of care (i.e., dispatch, mobile crisis, crisis receiving, crisis stabilization, follow-up care and support) -- especially in the frontier and sparsely populated areas of the state. However, a multi-county or regional approach is feasible.

Planning, development, implementation, and provision of behavioral health crisis services in a multi-county or regional system of care is daunting. However, we believe this may be the best option for crisis services for a significant part of Montana. A model we suggest (and stakeholders also pointed to) is the "hub and spoke" model. In this model, basic services are provided in a community/county to ensure the individual experiencing a crisis can be assessed in a safe environment, stabilized briefly if possible, and then transported to a longer-term facility (i.e., crisis receiving and/or crisis stabilization) as needed. The "hub and spoke" system enables individuals to receive care in their own community, close to family and friends, and in an environment with which they are familiar. It also increases the likelihood that a local behavioral health service provider (where they exist) can be involved from the beginning and throughout the course of treatment.

As suggested previously, it is recommended DPHHS/BHDD develop and implement pilot or demonstration projects to determine the feasibility of such an approach. Each demonstration project should be developed and overseen by a regional organization or entity (where one exists) and/or a regional multi-county coalition based on the model already being used in several "larger population" counties. We understand the challenges to such an effort are numerous, including:

- the determination of what counties should be part of the region;
- the Montana "local control" philosophy;
- a funding mechanism that involves the state and multiple county and city governments;
- law enforcement and emergency service providers from multiple jurisdictions;
- transportation within a county, within a region and outside a region;
- a mix of numerous small providers with limited capacity compared to larger comprehensive organizations with comprehensive services and satellite offices;
- the willingness of Community Access Hospitals to be a part of this solution⁹⁹; and
- the role of Tribal entities.

We recognize the current capacity within the state government to undertake such an effort is limited. Minimally there is a need to:

- Create a strategic plan (developed in conjunction with key stakeholders);
- Determine how to implement and fund such an approach;
- Embed a mechanism to ensure the provision of best and evidence practices;
- Define performance measures; and
- Monitor and evaluate the undertaking so successes can be embraced, and challenges addressed in consideration of bringing the pilot(s) to scale.

⁹⁹ Critical Access Hospitals (CAH) can be found in most counties in frontier Montana. Provided workforce and transportation challenges can be resolved, the CAHs are a mechanism for assessment and short-term stabilization components of the crisis continuum of care.

For this effort to be successful, we suggest DPHHS/BHDD view this as a research and development (R&D) endeavor and include input and guidance from a broad array of stakeholders, including the Montana Healthcare Foundation and Montana Public Health Institute which have been leaders in this effort. Finally, in lieu of developing “in house” capacity, we suggest the state consider contracting with an Administrative Services Organization (ASO) for this effort. There are several throughout the country that have the knowledge and skillset necessary to do this well.

In assessing the regions as currently mapped by DPHHS and other state agencies, we noted Montana has multiple defined regions, including Home and Community-Based Waiver (Medicaid) regions, Health Planning regions, Children and Family Services regions, American Indian Women’s Health regions, Prevention regions, Developmental Disabilities regions, and Local Advisory Council regions, etc. In addition, BHDD, Montana Healthcare Foundation, and Montana Public Health Institute are working to define and map technical assistance regions to support development of crisis services across the state. Notably, JG Research and Associates has also developed an impressive interactive regional mapping tool which, among other things, highlights the complexity and multiplicity of already defined health and human service regions in Montana.

In addition to looking at current regional maps for various services and systems in Montana, we became increasingly sensitive to the fact that Montanan’s highly valued philosophy regarding locally led (versus state-led) program development and service provision is a significant factor when considering regional configuration. Therefore, although we fully agree that a regional approach is the most pragmatic and effective approach to delivering statewide crisis services, to be effective and accepted, it is recommended DPHHS/BHDD leadership collaborate with and engage county-level stakeholders and planners to help define and develop crisis service regions -- beginning with regional demonstration programs.

Although we are not specifically defining the regions for DPHHS, we do recommend an incremental approach to regionalization of crisis services by funding and evaluating the impact of one regional crisis service demonstration project within each of the three 988 catchment areas. DPHHS/BHDD would provide up to five years of start-up and operation grants for the regional committees, with year-one supporting planning and partnership agreements, and years two through five (2 – 5) supporting the operation of multi-county (i.e., regional) mobile crisis services and/or crisis receiving and stabilization center(s).

Mirroring the State Crisis System Advisory Council, each of these demonstration sites should be guided by a multidisciplinary leadership group representing the counties within the proposed demonstration area including leadership from the 988 provider, hospital(s), community mental health and substance use treatment provider(s), FQHC(s), and first responder agencies. In addition to providing funding, DPHHS/BHDD would provide technical assistance and support to the three demonstration sites and committees.

In addition to launching and fine-tuning regional services, a key deliverable of the demonstration sites would entail regular assessments of their progress and impact. Further, the development and utilization of a bed/service tracking system would be an integral component of these efforts; DPPHS/BHDD would work closely with the local regional grantees to develop and implement the shared tracking system. Reporting on key performance measures for 988, mobile crisis, crisis receiving/stabilization, and aftercare would be integral to the demonstration sites funding requirements as well.

ADDENDUM: ADDITIONAL RESOURCES

CRISIS CONTINUUM DEVELOPMENT

NASMHPD – Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S. <https://nri-inc.org/media/1679/2020paper10.pdf>

NAMI – Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System <https://nami.org/NAMI/media/NAMI-Media/Public%20Policy/988-Crisis-Response-Report-November-FINAL.pdf>

NASMHPD – Crisis System Evaluation Tools & Resource Need Calculator <https://crisisnow.com/tools/>

PRI – Responding to Individuals in Behavioral Health Crisis via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers
<https://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf>

Peer Respite Action & Evaluation – Peer Respite Crisis Diversion Model & Examples
<https://www.peerrespite.com/>

MTM Services & National Council for Behavioral Health – Overview of Same Day Access Service Model
<https://static1.squarespace.com/static/59c005cd8a02c7dae8cd5e80/t/5e500feaf384a233dd5efdfe/1582305260891/So+You+Think+You%27re+Doing+Same+Day+Access+2-15-20+%28NC%29.pdf>

ADDRESSING CHALLENGES IN CRISIS SERVICES

Colorado General Assembly – Secure Transportation Behavioral Health Crisis
<https://leg.colorado.gov/bills/hb20-1284>

Michigan Psychiatric Care Improvement Project – MI-SMART Psychiatric Medical Clearance
<https://mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/>

Sierra Sacramental Valley Medical Society – SMART Medical Clearance Form and Process
<http://smartmedicalclearance.org/forms/>

WORKFORCE DEVELOPMENT AND STAFF RETENTION

SAMHSA Advisory – Peer Support Services in Crisis Care
https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP22-06-04-001.pdf

Oklahoma’s Peer Recovery Support Specialist Crisis Track Overview
https://www.nasmhpd.org/sites/default/files/TA%20Coalition%20OK%20Peer%20Crisis%20Track%20Overview_Final.pdf

Behavioral Health Education Center of Nebraska – Behavioral Health Workforce Initiative Annual Report
https://www.unmc.edu/bhecn/documents/bhecn_legislative_report_fy20-21_final.pdf

Montana State University – Behavioral Health Training Program
<https://healthinfo.montana.edu/bhwet/bhttp/index.html>

Montana State University – Community Health Worker (CHW) Training
<https://healthinfo.montana.edu/bhwet/bhttp/index.html>

NAMI – Frontline Professionals Wellness Resources <https://www.nami.org/Your-Journey/Frontline-Professionals>

BEST PRACTICE GUIDELINES AND TOOLKITS

SAMHSA – National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit

<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

NASMHPD – Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the

SAMHSA Crisis Toolkit <https://www.nasmhpd.org/sites/default/files/2020paper4.pdf>

VA Mental Health Services – Co-Occurring Disorders Toolkit <https://www.mentalhealth.va.gov/healthcare-providers/docs/VA-COD-Toolkit-One-Pagers-Final-508.pdf>

NASMHPD - 988 Convening Playbook: Mental Health and Substance Use Disorder Providers

https://www.nasmhpd.org/sites/default/files/988_Convening_Playbook_Mental_Health_and_Substance_Use_Disorder_Providers.pdf

NASMHPD – 988 Convening Playbook: Public Safety Answering Points (PSAPs)

https://www.nasmhpd.org/sites/default/files/988_Convening_Playbook_Public_Safety_Answering_Points_PSAPs.pdf

NASMHPD – 988 Convening Playbook: States, Territories, and Tribes

https://www.nasmhpd.org/sites/default/files/988_Convening_Playbook_States_Territories_and_Tribes.pdf

SAMHSA – Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders

https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf

SAMHSA – Concept of Trauma and Guidance for a Trauma-Informed Approach

https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Zero Suicide Toolkit <https://zerosuicide.edc.org/toolkit/zero-suicide-toolkitsm>

NIH – Ask Suicide-Screening Questions (ASQ) Toolkit <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials>

National Suicide Prevention Lifeline – Lifeline Best Practices for Helping Callers

<https://drive.google.com/file/d/1RuSEAJej-bUB-Kt8LIFxME0qK6BniFRG/view>

National Suicide Prevention Lifeline – Policy for Helping Callers at Imminent Risk of Suicide

<https://drive.google.com/file/d/1MKdm9HC5F0LFpuLTmL0IGW0dhLZeGDT2/view>

National Suicide Prevention Lifeline – Lifeline Policy for Helping Callers at Imminent Risk of Suicide: Call

Center Needs Assessment <https://drive.google.com/file/d/1aCxBfeaO4I9EJhADA21c175KKEtIKcS2/view>

National Suicide Prevention Lifeline – Suicide Risk Assessment Standards (2-page summary)

<https://drive.google.com/file/d/1F1EQ7Qvgz2wWABNYr4wyliudkHiKFATz/view>

The American Association of Suicidology – Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline

https://drive.google.com/file/d/1R3_wRDSN0EKjcvk9Vd3AmQ9xGfAXdggn/view

CSG Justice Center – Conducting Emergency and Non-Emergency Call Triage

<https://csgjusticecenter.org/publications/expanding-first-response/the-toolkit/call-triage/>

TAC – 911 Distressed Caller Diversion Program in Broome County, New York

<https://www.theiacp.org/sites/default/files/MHIDD/BroomeDiversion-508.pdf>

FUNDING STRATEGIES

NASMHPD - Funding Opportunities for Expanding Crisis Stabilization Systems and Services

<https://www.youtube.com/watch?v=XoZSEyOk2s>

TAC – Mobile Crisis Teams: A Strategy for Medicaid-Financed Crisis Response Services

<https://www.tacinc.org/resource/state-planning-guide-for-medicaid-financed-mobile-crisis-response/>

TAC - Mobile Crisis Teams: A State Planning Guide for Medicaid-Financed Crisis Response Services

https://www.tacinc.org/wp-content/uploads/2022/01/CHCF-Mobile-Crisis-Services-State-Planning-Guide-2021-01-24_Final.pdf

State of New York – Crisis Intervention Benefit: Mobile Crisis Component Benefit & Billing Guidance

https://omh.ny.gov/omhweb/bho/docs/mobile_crisis_intervention_guidance.pdf

Center for Medicare & Medicaid Services – Using Z Codes: The Social Determinants of Health (SDOH) Data

Journey to Better Outcomes <https://www.cms.gov/files/document/zcodes-infographic.pdf>

DATA TRACKING, MANAGEMENT, AND PERFORMANCE MEASURES

NASMHPD -- TA Coalition Webinar: Telling the Story: Data, Dashboards, and the Mental Health Crisis

Continuum <https://www.nasmhpd.org/content/ta-coalition-webinar-telling-story-data-dashboards-and-mental-health-crisis-continuum>

NASMHPD - Using Data to Manage State and Local Level Mental Health Crisis Services

https://www.youtube.com/watch?v=ffe4ziJ_G-A&list=PLmnqbpAK_1s_4zT3XDyTicZ6h-CbHxIbL&index=4

SAMHSA – Crisis Call Center Metrics: Part 1 Service & Efficiency [https://988lifeline.org/wp-](https://988lifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf)

[content/uploads/2019/02/CallCenterMetrics_final.pdf](https://988lifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf)

CRISIS BED REGISTRY DEVELOPMENT

NASMHPD - State Implementation of Crisis Bed Registries with 988 and Behavioral Health Crisis Services

https://www.youtube.com/watch?v=80Ey2KIE3I0&list=PLmnqbpAK_1s_4zT3XDyTicZ6h-CbHxIbL&index=2

CO-OCCURRING & SUBSTANCE USE DISORDERS

SAMHSA – The Case for Screening and Treatment of Co-Occurring Disorders <https://www.samhsa.gov/co-occurring-disorders>

Psychiatric Times – Substance Use Disorders in Crisis Settings: Engagement, Assessment, and Intervention Approaches <https://www.psychiatrictimes.com/view/substance-use-disorders-crisis-settings-engagement-assessment-and-intervention-approaches>

Journal of Advanced Generalist Social Work Practice – Co-Occurring Disorders among Clients of Emergency

Crisis Services https://springfield.edu/sites/default/files/inline-files/SC_Graduate_Social_Work_Journal_2020_Article7.pdf

SAMHSA -- Screening and Assessment of Co-Occurring Disorders in the Justice System

<https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf>

MHTTC – Substance Use and Co-Occurring Disorders Resources

<https://mhttcnetwork.org/centers/northwest-mhttc/substance-use-and-co-occurring-disorders-resources>

SUPPORTING TRIBAL CRISIS CARE SYSTEMS

Indian Health Service – AI/AN Community Crisis Response Guidelines

<https://www.ihs.gov/suicideprevention/communityguidelines/>

Zero Suicide – Toolkit: Best and Promising Practices for Implementation of Zero Suicide in Indian Country

<https://zerosuicide.edc.org/toolkit/toolkit-adaptations/indian-country>

LEGISLATING CRISIS SERVICES

NASMHPD – Model Bill for Core State Behavioral Health Crisis Services System

https://www.nasmhpd.org/sites/default/files/FINAL_988_Model_Bill_2-22-22_edited.pdf

NASMHPD – States’ Experiences in Legislating 988 and Crisis Services Systems

https://www.nasmhpd.org/sites/default/files/2022_nasmhpd_StatesLegislating988_022922_1753.pdf

NENA Suicide/Crisis Line Interoperability Standards

https://cdn.ymaws.com/www.nena.org/resource/resmgr/standards/nena-sta-001.2-2022_suicide-.pdf

SPECIAL POPULATIONS

Children and Adolescents

NASMHPD – Child and Adolescents Best Practice Models

https://www.youtube.com/watch?v=scht6Rvau1k&list=PLmnqbpAK_1s8XDDZO8pHeoZ35b4mRFLRv&index=6

SAMHSA – Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services

<https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/Mobile-Crisis-Response-&-Stabilization-Services-May-2016.pdf>

NIH – Strategies to Improve Mental Health Care for Children and Adolescents

<https://www.ncbi.nlm.nih.gov/books/NBK409137/>

Older Adults

SAMHSA – Helping Older Adults After Disasters https://store.samhsa.gov/sites/default/files/d7/priv/pep19-01-01-001_0.pdf

Institute on Aging – Friendship Line / National Crisis Line for People 60+

https://store.samhsa.gov/sites/default/files/d7/priv/pep19-01-01-001_0.pdf

Adultspan Journal – Crisis Model for Older Adults: Special Considerations for an Aging Population

<https://go.gale.com/ps/i.do?p=AONE&u=googlescholar&id=GALE|A210367839&v=2.1&it=r&sid=AONE&asid=af9a5eae>

Military Veterans

ServingTogether – Implementing Best Practices and Improving Collaboration for Crisis Care and Suicide Prevention Among High-Risk SMVF (Service Members, Veterans, and their Families)

<https://servingtogetherproject.org/implementing-best-practices-and-improving-collaboration-for-crisis-care-and-suicide-prevention-among-high-risk-smvf/>

Together with Veterans – Rural Veteran Suicide Prevention Program

<https://www.mirecc.va.gov/visn19/togetherwithveterans/>

LGBTQ+

AFSP – LGBTQ Crisis & Support Resources <https://afsp.org/lgbtq-crisis-and-support-resources>

APA – Best Practices for Mental Health Facilities Working with LGBT Clients
<https://www.apa.org/pi/lgbt/resources/promoting-good-practices>

Columbia Business School – Intervening for LGBTQ Youth in Crisis
<https://www8.gsb.columbia.edu/articles/columbia-business/intervening-lgbtq-youth-crisis>

Intellectual and Developmental Disabilities (IDD)

NASMHPD -- Crisis Services Response for IDD and Other Special Populations
<https://www.youtube.com/watch?v=HmXTFKUcLC4>

VERA Institute of Justice – Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities <https://www.vera.org/downloads/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities.pdf>

PROMOTING HEALTH EQUITY AND CULTURAL COMPETENCE

DHHS – Cultural Competency Program for Disaster Preparedness and Crisis Response
<https://thinkculturalhealth.hhs.gov/education/disaster-personnel>

DHHS – Improving Cultural Competency for Behavioral Health Professionals
<https://thinkculturalhealth.hhs.gov/education/behavioral-health>

NASMHPD -- Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States https://www.nasmhpd.org/sites/default/files/5_Disparities_508.pdf

SAMHSA – TIP 59: Improving Cultural Competence <https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>

Minnesota DOH: Conducting a Health Equity Data Analysis: A Guide for Local Health Departments
<https://www.health.state.mn.us/data/mchs/genstats/heda/hedaguide.pdf>

COMMUNITY EDUCATION AND MESSAGING

Action Alliance – 988 Messaging Framework
<https://suicidepreventionmessaging.org/988messaging/framework>

NAMI – 988 Crisis Response Research & Public Perceptions <https://nami.org/NAMI/media/NAMI-Media/Public%20Policy/NAMI-988-Crisis-Response-Report.pdf>