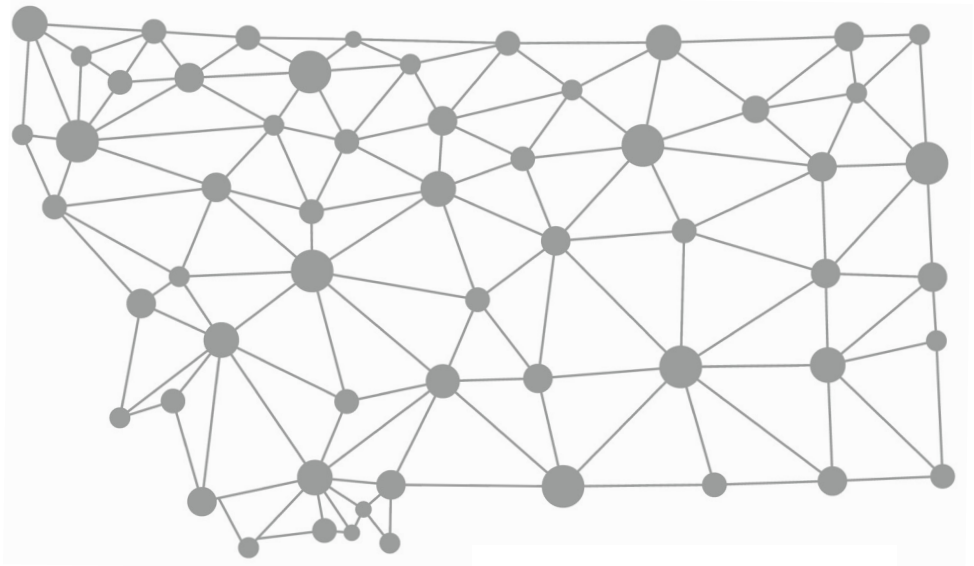# Eastern Montana Behavioral Health Crisis Response and Jail Diversion

Strategic Plan

PREPARED BY
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2017

Background

The 2015 Montana Legislature passed House Bill 33, which allowed Montana counties to apply for funding to "expand behavioral health crisis intervention and jail diversion services to areas of the state that lack services."[1] Dawson County and the Glendive Medical Center (GMC) partnered with 16 other Eastern Montana counties to apply for this funding to develop a plan for behavioral health crisis intervention and jail diversion services and to support the re-opening of GMC's inpatient behavioral health unit. A portion of the House Bill 33 funds received were allocated to develop this plan for behavioral health crisis response and jail diverstion services in Eastern Montana. To support its development, the GMC and EMCMHC hired a team of three consultants.

Methodology

The team of consultants hired for this project were Jane Smilie, Katie Loveland, and DeAnn Carr. From January 1 to April 30, 2017 the consultants worked with stakeholders in Eastern Montana and experts across the country to gather the information that is included in this plan.

Key data gathering initiatives conducted for the project include:

• A literature review of the published evidence for regional behavioral health crisis services in rural areas

• Semi-structured interviews with 11 national stakeholders with experience designing or implementing regional crisis services in rural areas

• A full-day in-person facilitated strategic planning meeting on March 29th, 2017 at GMC, with 70 stakeholders from across the region in attendance

• Thirty semi-structured interviews with key identified stakeholders in Eastern Montana including county attorneys, sheriffs, hospital CEOs, primary care and behavioral health care providers, judges, and county commissioners

• An analysis of available population and organizational-level data on behavioral health crisis including hospital discharge data, client data from the EMCMHC, vital records data on intentional self harm and historical data from the GMC Behavioral Health Unit

• A review of policy, payment, regulatory and workforce issues affecting the provision of crisis response and jail diversion services in Montana

• Three electronic surveys to gather information on the impact of behavioral health crisis on various agency types. The surveys conducted include:

• The Eastern Montana Behavioral Health Provider Survey: Sent to 26 behavioral health providers working for the Eastern Montana Community Mental Health Center. Nineteen responses were received for a response rate of 73%

- The Eastern Montana Emergency Medical Services and Behavioral Health Crisis Survey: Sent to 23 directors of Emergency Medical Service organizations in Eastern Monana. Six responses were received for a response rate of 26%

- The Eastern Montana Law Enforcement and Behavioral Health Crisis Survey: Sent to 21 sheriffs and chiefs of police in Eastern Montana. Eight responses were received for a response rate of 38%

The results of these assessments and inquiries were used to develop the background information in this report, identify the strengths and weaknesses of the current behavioral health crisis response system in Eastern Montana and inform recommendations to strengthen the regionalized crisis response system in the region.

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An introduction to the region

The 17 eastern Montana counties that partnered to develop this plan are: Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Phillips, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Treasure, Valley and Wi-baux. The lead agencies for this project are the Glendive Medical Center (GMC) and the Eastern Montana Community Mental Health Center (EMCMHC).
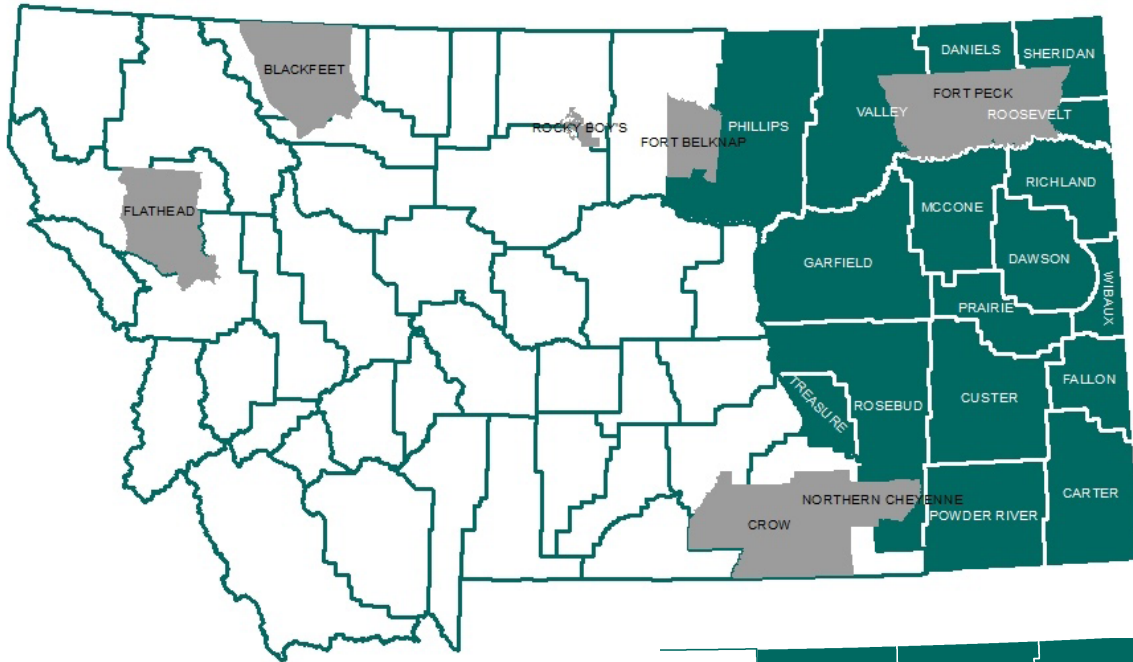
This 17 county region encompasses 48,071 square miles with a total population of 83,996 people for a population ratio of 1.74 per square mile. The region includes all or part of three American Indian Reservations: Fort Peck, Northern Cheyenne and Fort Belknap.

A total of 16 critical access hospitals provide in-patient and emergency medical services in the region. The total number of beds in these 16 hospitals is 367.
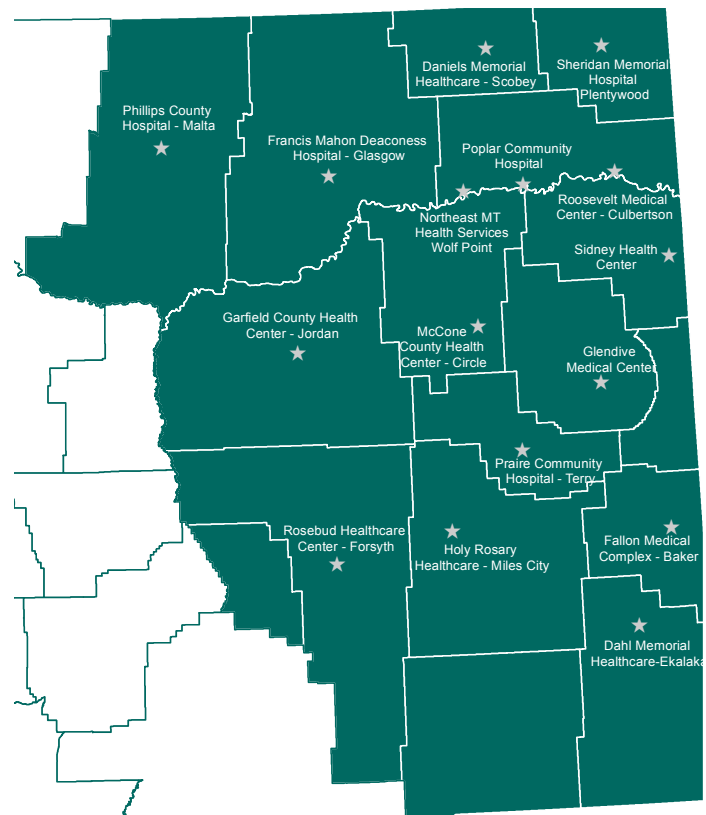
Community-Based Mental Health Services in the Region

The primary mental health provider in the region is EMCMHC. Established in 1967, the EMCMHC currently operates full time mental health center facilities in Sidney, Glendive, Miles City, Forsyth, Plentywood, Glasgow, and Wolf Point, while providing part time community-based mental health services in Baker, Broadus, Culbertson, Jordan, Malta, Scobey, Wibaux, and Circle. The EMCMHC is one of the few organizations in Montana that is dually licensed as a State Approved Community Mental Health Center and a State Approved Substance Abuse Provider. EMCMHC is licensed as a state approved provider in all of the counties in this region except McCone, Dawson, Richland, Prairie and Wibaux, preventing them from providing substance use disorder treatment services in their clinics in Glendive and Sidney. The substance use prevention program through the EMHMHC supports two full time substance use prevention specialists who coordinate substance use prevention activities across Eastern Montana as well as the services of Licensed Addiction Counselors across the region.   SUD services are provided at the clinical facilities in Baker, Broadus, Forsyth, Wolf Point, Malta, Glasgow, Plentywood, Culbertson, Miles City, and at the Community Health Center in Jordan.

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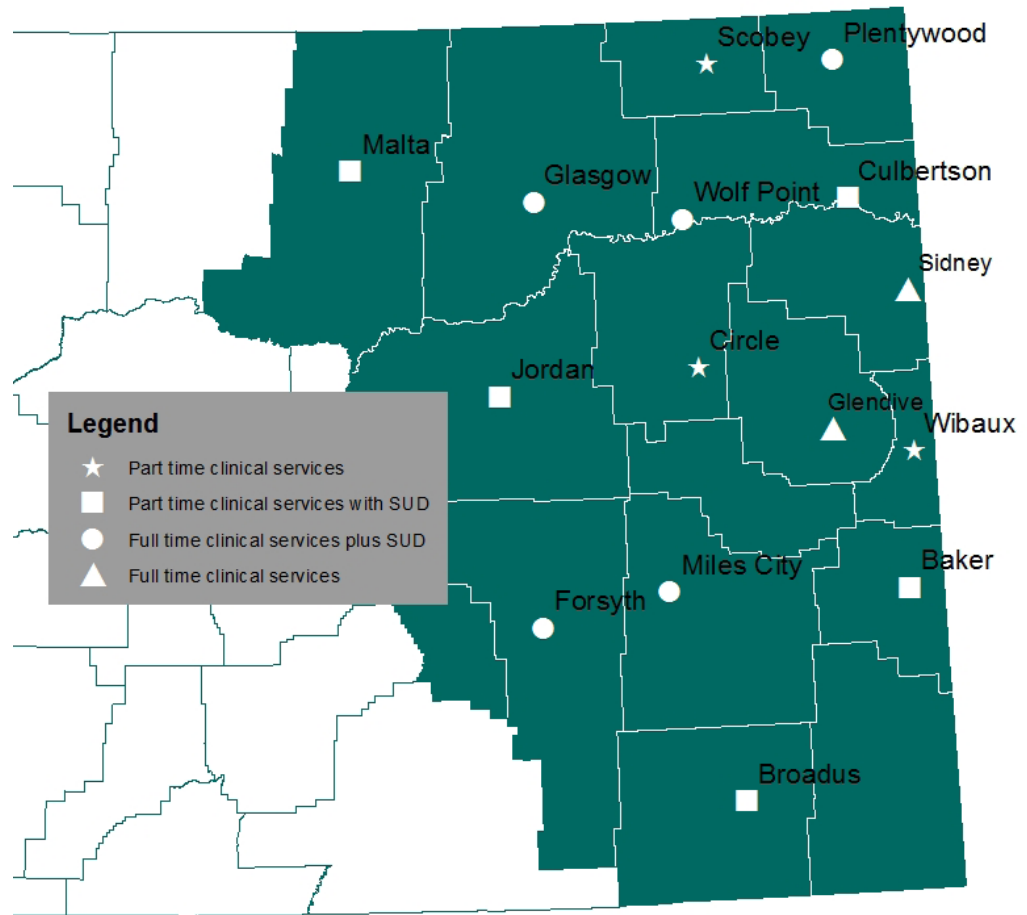
Why crisis services?

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health crisis services as "a continuum of services that are provided to individuals experiencing a psychiatric emergency."[2] The most common psychiatric emergencies are "patient-initiated threat of harm to self, health care personnel, or others in the patient's sphere of influence." Crises can also commonly include emotional distress, substance use disorders, psychosis, or other rapid changes in behavior.[3] SAMHSA notes that a primary goal of crisis services is to ensure that individuals experiencing a psychiatric emergency are stabilized, that their symptoms and underlying problems are addressed and that services are provided in the **most appropriate and least restrictive setting.**

Unfortunately, in the U.S., many individuals experiencing a behavioral health crisis, especially those threatening harm to others, are processed through our justice and jail systems instead of receiving appropriate behavioral health care. The U.S. Department of Justice estimates that more than half of all inmates in the U.S. have a mental illness, including 64% of all individuals held in local jails.[4]

Sending individuals in a behavioral health crisis to jail, the emergency department or the hospital are high cost options and are often inappropriate or ineffective forms of response. In one study in Texas, the cost of community-based services was estimated at $12 per day, compared to $137 for a jail bed and $986 for the emergency room.[5]

A study in Philadelphia found a 54% recidivism rate for individuals jailed with a mental illness and a 68% recidivism rate for those incarcerated with a co-occurring mental illness and substance use disorder.[6] Clearly, jailing these individuals is not solving the problem of behavioral health crises and re-entry into the justice system.

Warm lines → Crisis hot lines → Mobile crisis teams → 23 hour crisis stabilization beds → Short-term crisis stabilization facilities

CORE CRISIS SERVICES

To address the growing concerns about appropriately responding to mental health crises, a variety of crisis response and jail diversion programs have been developed nationwide. SAMHSA promotes the development of a range of evidence-based core crisis services such as crisis warm lines, crisis hot lines, mobile crisis teams, 23-hour crisis stabilization facilities, and short term crisis stabilization facilities.[7] However, like most systems developed and studied in the United States, these crisis services and diversion programs were often developed in populated urban centers. Thus, a mobile crisis team serving in Chicago might cover an area of five square miles and respond face-to-face to thousands of individual crises a year. A short term crisis stabilization facility in Los Angeles could coordinate with a dozen large healthcare facilities and mental health centers in a 20-30 mile radius to provide ongoing stabilization services to their clients. These urban models must be adapted for frontier areas like Eastern Montana where substantially smaller populations are spread out over much larger areas. The challenge for Eastern Montana is translating these best practice models into a regional approach that works in a sparsely populated, frontier area covering thousands of square miles.

Evidence for effectiveness of regional crisis services in rural areas

Not surprisingly, the published research on the effectiveness of regional crisis services in rural areas is limited. The following is a summary of the key findings from a number of studies that quantify the feasibility and impact of these types of services.

• An Australian study assessed the impact of a regional/rural crisis Crisis Assessment Treatment (CAT) service, which was designed to respond to and manage psychiatric crisis presentations within the community. The multidisciplinary CAT team consisted of a psychiatrist, medical, nursing and allied health staff. The CAT team provided 24/7 on-call outreach and emergency service that included crisis assessment and treatment services to triage patients and serve a gate-keeping role for all potential admissions. The study found there were proportionately fewer psychiatric hospital readmissions after the development of the CAT service and that psychiatric hospital admissions were more likely to be influenced by illness severity and diagnostic considerations post-CAT (meaning that those admitted to the hospital for psychiatric admissions were appropriately targeted).[8]

• A 2005 study describing a rural community mental health center that developed regional crisis services designed to reduce the need for hospitalization and more restrictive forms of care found that adaptations from the traditional SAMSHA core crisis services were needed in a rural area. The center in the study supported 24/7 crisis hotlines and professionals on call, crisis beds and 72 hour hold facilities. On-site crisis services at the center were preferred to mobile crisis in this setting because of the rural nature of the area, long travel times and burnout of the mobile crisis professionals. The study found that 60% of the clients in severe crisis were female and that 56% of the crises occurred during normal center business hours, with only 12% occurring after midnight, including lower utilization on weekends. The development of these robust crisis services reduced the inpatient admission referrals for the center's clients by 40%.[9]

• A 2010 study of mental health services in rural jails, including Montana, found that rural jail administrators and mental health providers "understand the need for mental health services for jail inmates but are constrained by inadequate community mental health resources, lack of coordination with community mental health providers, and infrastructure challenges including facilities, transportation, and legal processes." The researchers suggest that rural jails consider the following as they attempt to develop more mental health services and jail diversion programs:

• Support the development of more community-based mental health and substance abuse services to help place individuals with mental illness in appropriate settings and to improve follow-up care for released inmates.
• Foster relationships between rural jail administrators and community mental health providers to help develop creative solutions to local problems.
• Support regular, cross-sector meetings between behavioral health and justice system stakeholders
• Better utilize technology such as videoconferencing, to simplify pre-commitment hearings and assessments.
• Develop short-term holding facilities as an alternative placement for individuals who need brief interventions to protect themselves and society.[10]

Evidence for effectiveness of regional crisis services in rural areas continued

• A study that used focus groups of local law enforcement agencies running Crisis Intervention Team (CIT) Programs in rural communities found that CIT teams can be successfully implemented in rural areas.   However, the study indicated rural teams report a lack of resources in their communities for individuals with mental illness and lack data on the number and types of offenders with mental illness. The study included the following suggestions for rural communities developing CIT programs:

- Engage in cross-system training to better understand the role and perspectives of other partners
- Be creative in the use of local resources and talent to sustain CIT in rural communities

- Engage advocacy groups such as NAMI to champion the development and sustainability of CIT
- Determine the local needs of your community through activities like process mapping to understand how CIT can be effective.[11]

CONCLUSION

Though the published literature on regionalized crisis services and jail diversion programs in rural areas is limited, the studies that do exist point to the potential for developing effective programs as long as stakeholders across sectors are engaged and willing to develop adaptive, innovative solutions that meet community needs.

History of crisis services in Eastern Montana

Like many places in the country, counties in rural, Eastern Montana struggle to respond effectively to individuals in acute behavioral health crisis. In a frontier region like Eastern Montana, an individual experiencing a behavioral health crisis may present hundreds of miles from a hospital, and the nearest hospital may not have licensed behavioral health staff available to properly assess the patient and determine how to respond. As is true nationally, the first point of contact for individuals in crisis is often law enforcement. Without adequate training or community-based resources for referral, law enforcement officials who encounter an individual in crisis may have no option but to take the individual to a jail or call 911 so that he or she can be transported to the nearest hospital. Law enforcement agencies (LEAs) and Emergency Medical Services (EMS) in Eastern Montana report that behavioral health crisis calls are a routine part of their work. Sheriffs and city police chiefs in Eastern Montana estimate that 22% of the calls they respond to are related to mental health crises and 60% are related to substance abuse. Interestingly, law enforcement agencies in Eastern Montana estimate that behavioral health crises

are more common in their work than EMS agencies. EMS directors in Eastern Montana estimate that 13% of their calls are related to mental health crises and 26% are related to substance abuse.

Individuals in behavioral health crisis who are not sent to jail may be taken via ambulance or patrol car to an emergency department or transported over long distances to an inpatient behavioral health unit in a hospital. The burden of transporation in Eastern Montana to the Montana State Hospital (MSH) in Warm Springs is substantial. Warm Springs is in the western portion of the state and is more than 450 miles away from some of the largest communities in Eastern Montana including Wolf Point, Glendive and Sidney. Round trip, the drive from these communities is more than 14 hours. And yet, most LEAs and EMS services report that transport to the MSH is an established part of their work. Seventy five percent of LEAs and 50% of EMS organizations in Eastern Montana report transporting individuals in behavioral health crisis to the MSH. A snapshot of the administrative data from the MSH from September to December 2016 showed between 9 and 12 patients from Eastern Montana were in the MSH at any point during that time period, with two-thirds of patients committed forensically and the remaining third

commitmented civilly. Despite the long distances to travel, Eastern Montana patients during this time period were just as likely as patients from all parts of the state to be committed to the MSH.[12]

In addition to transport to the MSH, 87% of LEAs in Eastern Montana report transporting individuals in crisis to other inpatient healthcare settings such as local community hospitals or hospitals in Billings. Though EMS agencies report transporting individuals to these high cost, intensive healthcare settings, they do not report using their ambulances to transport individuals to lower levels of care. EMS services in Eastern Montana report they do not transport individuals to community-based mental health services.

When a person in Eastern Montana is transported to the MSH or Billings before being fully assessed by a mental health professional, and causing a local law enforcement officer to leave his or her jurisdiction for up to two full days, it is clearly a drain on human and financial resources. However, without a clear plan and system to respond to mental health crises in the region, this "worst case scenario" can be the only option.

Worst Case Crisis Response System in Eastern Montana (Current)
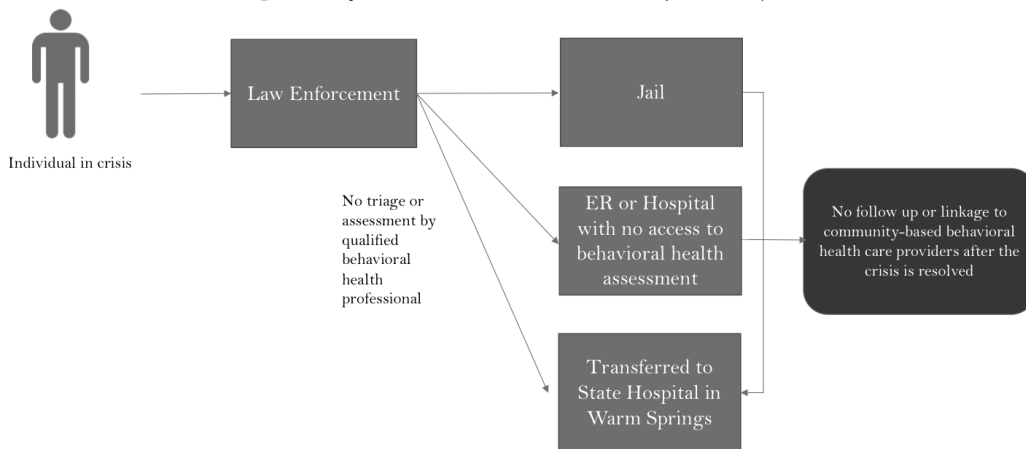
Though some patients in behavioral health crisis in Eastern Montana likely experience the "worst case scenario", there are also many organizations in the region working to provide adequate crisis services. A summary of the available services is outlining on the following pages.

24/7 Behavioral health crisis line

Ater 5 pm and on weekends, hospitals and law enforcement agencies can receive consultation from EMCMHC staff through their crisis line. After normal business hours, office lines re-direct calls to the hotline number and EMCMHC staff provide telephonic triage services to individuals, family members or hospitals who call needing assistance with a behavioral health crisis. Those who call may have their concerns addressed over the phone, be directed to the nearest emergency department for care or may be referred to EMS or LEAs. Whenever possible and necessary, EMCMHC staff are dispatched the next day to the individual's location for face-to-face assessment and follow up care.

In 2016, the EMCMHC crisis line fielded 133 calls, for an average of 11 per month, with a low of only two in July compared to 18 in February. Of all the calls received in 2016, 60% were for existing or previous clients already known to the EMCMHC and the remaining 40% were new clients.

There is evidence that the crisis line may be underutilized by some agencies in the region. Only one out of the six responding EMS organizations in Eastern Montana reported that their EMTs or paramedics call the EMCMHC (either the local clinic or the 24 hour crisis line) for assistance with individuals in mental health crisis. This agency reported typically using the line once, though sometimes more often. LEAs in Eastern Montana are more likely to report using the crisis line. Fifty percent of the LEAs surveyed reported using the line and those who reported using it noted that they call between two and five times a month.

EMCMHC Crisis Line Calls Per Month, 2016
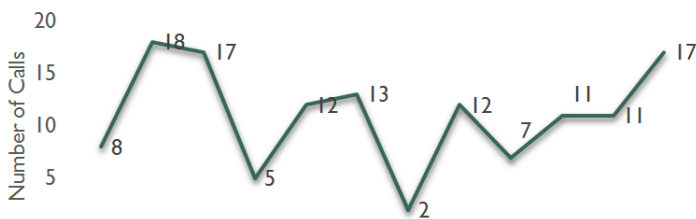
Type of Client Assessed through the EMCMHC Crisis Line, 2016

Not current or previous Client 40%

Existing or previous client 60%
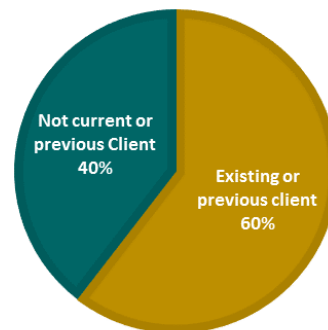
Secure crisis room in Frances Mahon Deaconess Hospital in Glasgow

Frances Mahon Deaconess Hospital in Glasgow has a secure crisis room, the only such room in Eastern Montana. In 2011, Valley County was awarded a grant from the state to retrofit a room in their hospital as a secure crisis room, to train law enforcement officers, and to pay for costs related to commitment proceedings. In subsequent years, the county has received additional county matching grant funds to continue these efforts. From July 1, 2015, through June 30, 2016, the room was used 16 times. Four of the clients who used the room were sent to the MSH, two received community commitments, one went to an acute psychiatric facility and nine went home.

Crisis services in hospitals

The EMCMHC currently provides a number of behavioral health crisis services for clients in the region. The EMCMHC has an agreement with 11 hospitals across the region to provide face-to-face or telephonic consultation and assessment for clients who present in their emergency departments in behavioral health crisis during weekday business hours. The hospital facilities with which EMCMHC currently has an agreement are:

-Holy Rosary Healthcare in Miles City
-Sidney Healthcare
-Frances Mahon Deaconess Hospital in Glasgow
-Glendive Medical Center
-Rosebud Health Care Center in Forsyth
-Poplar Community Hospital
-Trinity Hospital in Wolf Point
-Fallon Medical Center in Baker
-Sheridan Memorial Hospital in Plentywood
-Daniels Memorial Hospital in Scobey and
-Phillips County Hospital in Malta

Legend
○ Hospitals with an EMCMHC crisis agreement
● Hospitals without an agreement
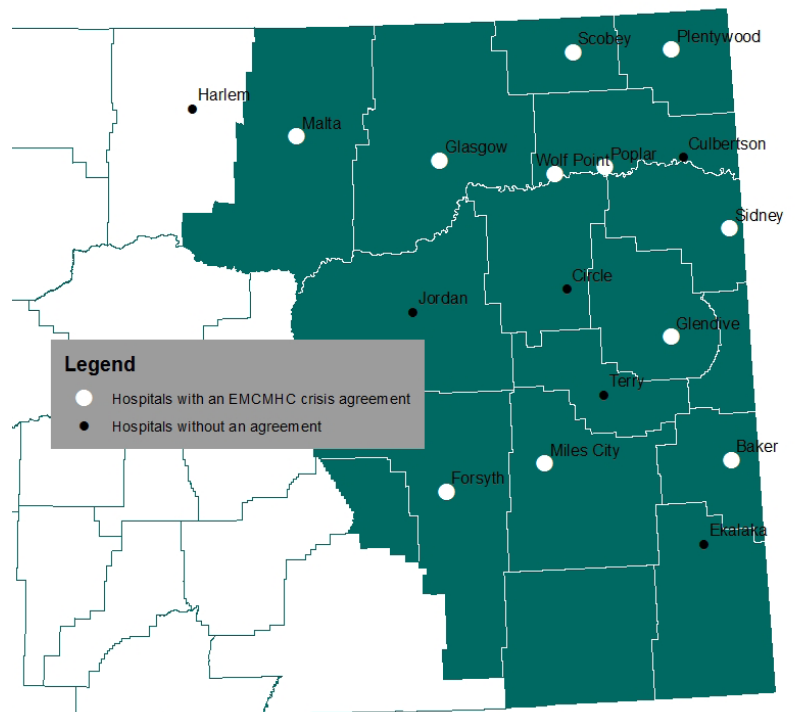
Telehealth assessment for crisis

In 2014, the Leona M. and Harry B. Helmsley Charitable Trust provided three-year staggered grants to a number of hospitals in Eastern Montana to purchase telemedicine equipment for their EDs and cover fees for utilizing the Avera eCare Telemedicine Network. Using this money, 12 of the 16 hospitals in the region now have access to the 24/7 medical assessment services provided by board certified emergency room physicians and nursing staff in Sioux Falls, South Dakota through the Avera eCare Telemedicine Network:

The hospitals in the region that currently utilize Avera are:

-Holy Rosary Healthcare in Miles City
-Glendive Medical Center
-Poplar Community Hospital
-Trinity Hospital in Wolf Point
-Fallon Medical Center in Baker
-Sheridan Memorial Hospital in Plentywood
-Daniels Memorial Hospital in Scobey and
-Phillips County Hospital in Malta
-Roosevelt Medical Center in Culburtson
-Garfield County Health Center in Jordon
-McCone County Health Center in Circle
-Prairie Community Hospital in Terry and
-Dahl Memorial Healthcare in Ekalaka

Through this network, rural emergency departments can access a range of medical assessments including stroke, trauma and heart attack. Recently, Avera has also added behavioral health assessments to their suite of services. Some sites in the region, such as GMC, report that they rely heavily on the Avera system for crisis behavioral health assessments. According to Avera data, in the month of March 2017, GMC utilized the system for four assessments, all of which were for behavioral health. Providers at other sites in the region interviewed for this project report rarely using the Avera system, despite having access to the equipment, or being unaware of its capacity to support behavioral health assessment.

Legend
● Hospitals without Avera
▲ Hospitals with Avera
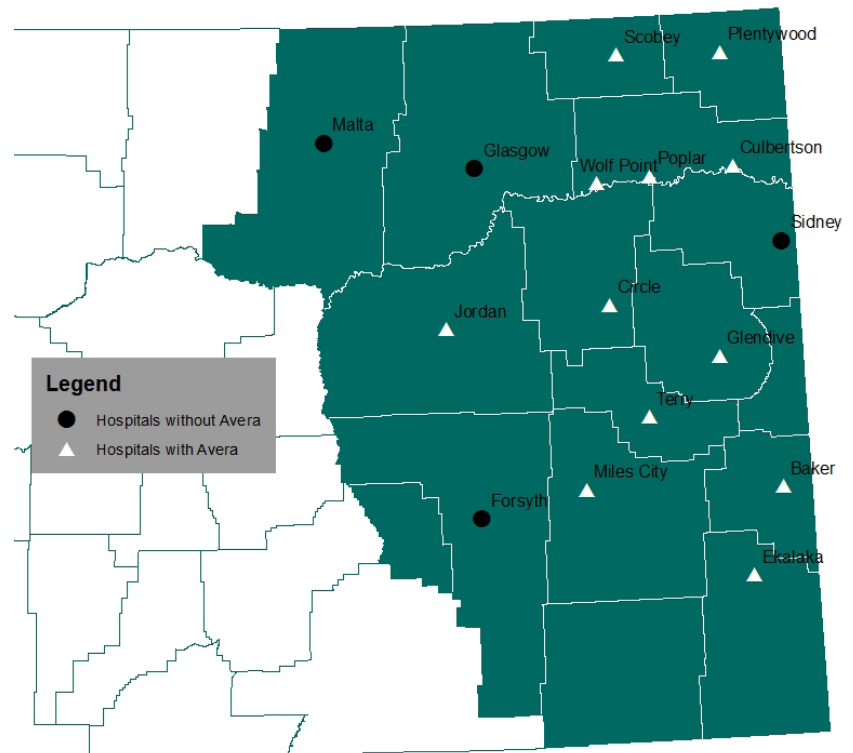
Inpatient behavioral health

BILLINGS CLINIC

Currently, when a patient in a behavioral health crisis in Eastern Montana is determined to require a higher level of care in an inpatient setting, he or she must be transported out of the region. As described earlier, individuals from Eastern Montana often receive services in both the ED and inpatient psychiatric unit at Billings Clinic. The facility estimates that 50% of its ED clientele is from outside the immediate Billings service area and that one in three presentations at the ED is for behavioral health. Clients assessed in the Billings Clinic ED may be admitted to the Inpatient Psychiatric Unit. In FY 2016, of the 2,620 total amissions to this unit, 184 (7%) were from Eastern Montana. All 17 counties in the region had at least one admit in 2016, with the majority coming from Rosebud (57), Custer (34), and Roosevelt (24).

Due to the increasing demands of behavioral health patients at the ED, and the long average wait times in the ED for behavioral health assessment, Billings Clinic is planning to open a behavioral health crisis stabilization center later this year. The vision for this center is to allow individuals experiencing a crisis to avoid the ED or hospital and the long waits for service. In this center, a client will be assessed and begin receiving services immediately with an emphasis on connecting individuals with community services.

Some clients are already being linked back to community-based behavioral health care through Billings Clinic, either in person or over the Eastern Montana Telehealth Network. Of the 18,904 outpatient visits to the clinic in 2016, 1,089 were from Eastern Montana (6%).

GLENDIVE MEDICAL CENTER

Some of the need to transport individuals to both Billings and Warm Springs will be lessened when the GMC reopens its behavioral health unit. The GMC is a full-service, 25-bed critical access acute care hospital with 24-hour emergency care, full medical and surgical services, and an attached 71-bed skilled extended care facility.

In 2010, the GMC opened a four bed inpatient behavioral health unit. The unit was in an older part of the hospital that had been retrofitted to care for behavioral health clients. The GMC employed a psychiatrist. Unfortunately, the psychiatrist was recruited to work in the western part of the state in 2015, forcing the GMC to close the behavioral health unit in May 2015.

GLENDIVE MEDICAL CENTER
BEHAVIORAL HEALTH UNIT ADMISSIONS DATA 2001-2015

593 Total
from 16 of the 17 counties

Three out of four from Dawson, Custer, Richland or Roosevelt Counties

64% Major depressive disorders

5.5 days
Average length of stay

49 average age

60% female

Inpatient behavioral health continued

Data from when the GMC inpatient behavioral health unit was open from 2001-2015 indicates that the unit did serve a regional role. There were a total of 593 admissions to the unit during this time period, from 16 of the 17 counties in Eastern Montana. Not suprisingly, three out of four of these admissions were from the most populous counties in the region, Dawson, Custer, Richland and Roosevelt. The average length of stay in the unit was 5.5 days. The majority of patient admissions were female (60%) and the average patient age was 49. Major depressive disorders were the most common primary diagnosis for patients (64%). The majority of admissions were covered by Medicare, Medicaid or private insurance, though one in five admissions was self-pay.

Payer, Glendive Behavioral Health Unit, 2001-2015

- IHS 5%
- Other 2%
- Medicaid 19%
- Medicare 25%
- Private 28%
- Self Pay 21%
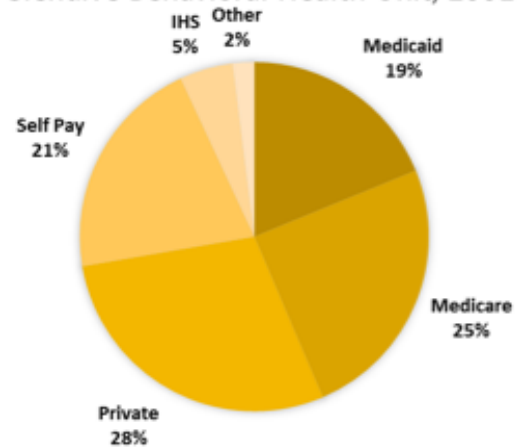
Emergency department visits for crisis

Since the inpatient unit has been closed, the GMC ED has continued to see patients in behavioral health crisis. In 2016, there were 134 emergency department visits for behavioral health at GMC. Eighty eight percent of the patients admitted to the ED were from Dawson County, but individuals from 9 of the 17 counties in Eastern Montana were admitted for behavioral health concerns in 2016. Therefore, this facility continues to receive behavioral health patients from a majority of counties in the region. Almost half of the visits to the GMC ED were

GLENDIVE MEDICAL CENTER-2016
EMERGENCY DEPARTMENT VISITS FOR BEHAVIORAL HEALTH

134 Total
from 9 of the 17 counties

88% from Dawson County

78% Discharged with no additional services

Admitted to GMC, another hospital or crisis setting 17%

65% Anxiety or panic disorders

covered by Medicaid, while one in five were self pay. Among all of the behavioral health visits to the GMC ED in 2016, 17% were eventually admitted to GMC, another hospital or a crisis setting, while 78% were discharged with no additional services. The remaining 5% of patients were discharged to the jail, the courts or transferred to another crisis setting. Unlike the inpatient behavioral health unit, the most common diagnoses in the emergency room were anxiety or panic disorders (65%).

GMC Emergency Room Behavioral Health Admissions by Payor, 2016

Private 17%
Medicaid 46%
Self pay 18%
Medicare 19%
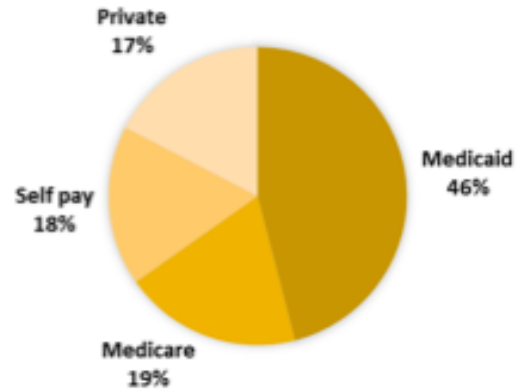
Re-opening of the GMC Behavioral Health Unit

In 2017, the GMC will utilize funding from HB 33 to re-open its inpatient behavioral health unit. This four bed unit will be in a newly designed section of the hospital specifically tailored to the security and care needs of a behavioral health unit. The unit will be a fully equipped, locked unit with a secure room to stabilize patients. The facility has been specifically designed to meet the needs of behavioral health patients, from the equipment room to specialty windows and doors. The GMC is in the process of

recruiting two psychiatrists, two mid-level providers and a licensed clinical social worker to staff the unit. When it is re-opened, the unit will be the only one of its kind between Billings and Bismarck, North Dakota.

Thus, with the current system that is in place in Eastern Montana, a best case scenario response to a behavioral health crisis would be the following:

Best Case Crisis Response System in Eastern Montana (Current)
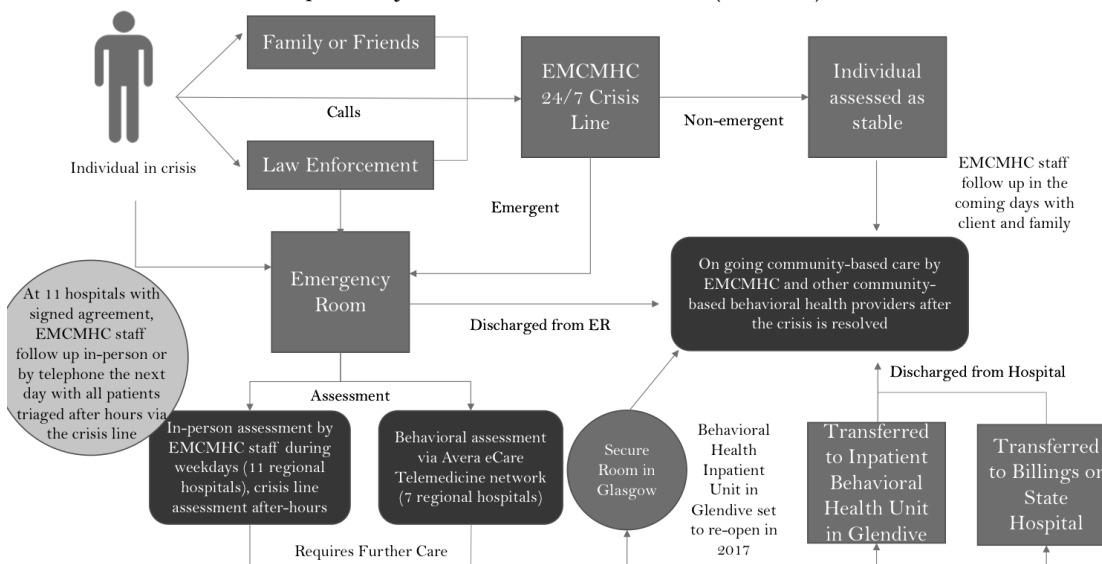
Quantifying the impact of behavioral health crises in Eastern Montana

Though behavioral health crises are difficult to define and capture in clinical and billing data, we analyzed a number of sources to assess the impact of behavioral health crises in the region including:

- Medicaid data showing the utilization of mental health and SUD related treatment and prescriptions in the region for low income adults and children
- Hospitalization data (both inpatient and ER) for behavioral health concerns in the 16 critical access hospitals that serve the region
- Vital records data on intentional self harm (suicide)

Behavioral health services and Medicaid

The Montana HELP Act expanded Medicaid coverage to adults up to 138% of the Federal Poverty Level effective January 2016. This law caused a surge in enrollment in Medicaid. Eastern Montana saw a 64% increase in Medicaid enrollment from 2013 to 2016 driven by an 135% increase in the number of Medicaid enrolled adults. In all, 21,566 individuals are now enrolled in Medicaid in Eastern Montana. This constitutes 26% of the entire population, up from 16% in 2013.

Medicaid and CHIP enrolled individuals, Eastern Montana, 2013-2016

	2013	2014	2015	2016
18+	4,693	5,418	5,946	11,026
0-17	8,480	9,560	9,829	10,540

■ 0-17 ■ 18+
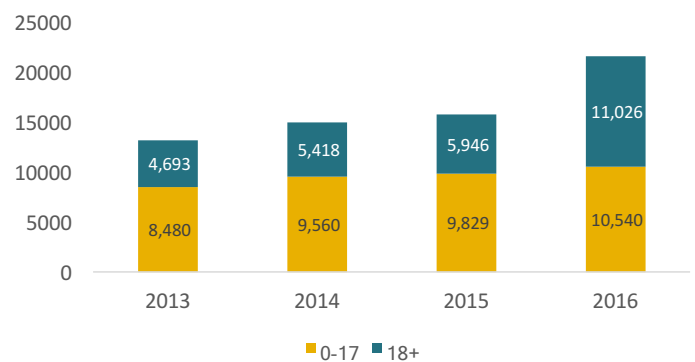
Individuals in Eastern Montana with any mental health prescription on Medicaid or CHIP, 2013-2016

	2013	2014	2015	2016
18+	983	1,139	1,227	2,655
0-17	714	768	717	797

■ 0-17 ■ 18+
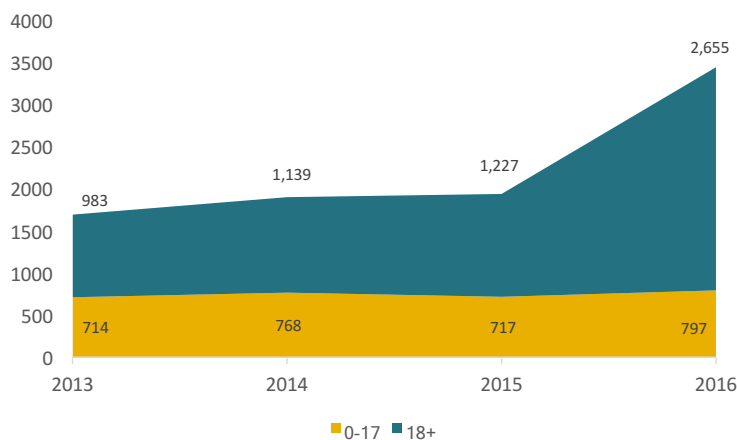
Increased enrollment brought an increase in the number of individuals receiving care for behavioral health concerns through Medicaid. The number of adults with a prescription related to mental health grew at an even faster rate than the increase in enrollment, up 170% from 2013 to 2016. In 2016, 3,452 individuals on Medicaid in Eastern Montana received at least one mental health prescription. In all, 8% of the children on Medicaid or CHIP (the Children's Health Insurance Plan) in Eastern Montana and 24% of the adults on Medicaid received a mental health prescription in 2016.

Behavioral health services and Medicaid

Other behavioral health-related services also increased as a result of Medicaid expansion. There were over 3,300 individuals on Medicaid in Eastern Montana with an outpatient visit for mental health in 2016, compared to only 1,900 in 2013 (a 70% increase) and the number of adults in Eastern Montana on Medicaid with Severe and Disabling Mental Illness (SDMI) increased 89% from 2013 to 2016. Individuals being treated for substance use disorders (SUD) also increased under Medicaid expansion. In 2013, only 210 individuals in Eastern Montana on Medicaid had an outpatient visit for SUD. In 2016, the number more than tripled to 674.

Number of individuals on Medicaid in Eastern Montana with a mental health outpatient visit or with Severe and Disabling Mental Illness, 2013-2016
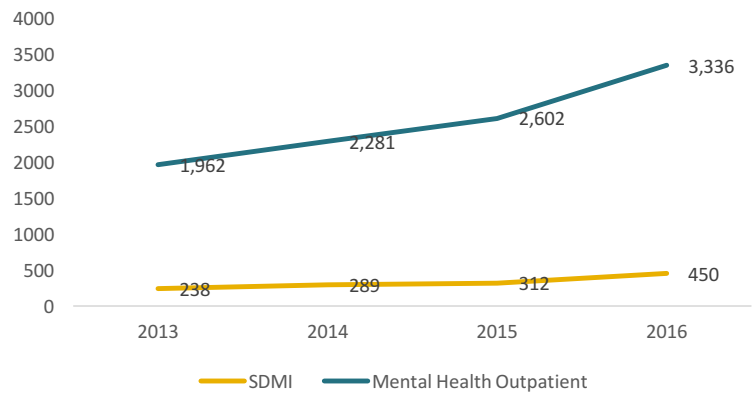
Crisis events among EMCMHC clients

Insurance type for EMCMHC Clients experiencing a crisis in the last year

Other 17%
Medicaid 33%
Medicare 3%
Private Insurance 8%
Self Pay 39%
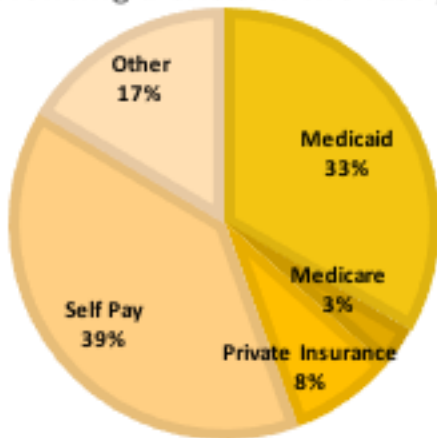
From February 2015 to January 2016, clients of the EMCMHC experienced a total of 535 crisis events, amounting to more than one per day. In all, 274 total clients had crisis events with 103 (38%) experiencing more than one event during the twelve month period. Almost three out of four EMCMHC clients experiencing a crisis in the last year (72%) were insured through Medicaid or were self-paying clients. Only 8% have private health insurance. In contrast, 66% of all Montanans have private health insurance. (Source: American Community Survey, 5 year estimates, 2011-2015).

Hospitalizations related to SUD

To quantify the impact of substance use and mental health on hospitalization in Eastern Montana, the Montana DPHHS Office of Epidemiology and Scientific Support ran an analysis using the Healthcare Cost and Utilization Project's definition of "Hospitalizations Involving Mental Health and Substance Use Disorders Among Adults, 2012." These definitions focus on the mental health aspect of substance use, and are different than other definitions that focus on other aspects of substance use."[13]

Of the 29,000 inpatient admissions to Montana residents in the chosen counties during 2010 through 2014, excluding those for pregnancy and childbirth, 8.9% had at least one diagnosis for a substance use disorder with total annualized charges of $11 million. The percentage slightly increased from 2010 to 2014 (range: 7.3% to 10.4%).

TABLE 1. INPATIENT ADMISSIONS WITH ALL-CAUSE SUBSTANCE USE DISORDERS, EASTERN MONTANA RESIDENTS, MONTANA HOSPITAL DISCHARGE DATA SYSTEM, 2010-2014

AGE RANGE	0-17	18-44	45-64	65+
NUMBER OF ADMISSIONS	96	991	1,063	408

TABLE 2. INPATIENT ADMISSIONS WITH ALL-CAUSE SUBSTANCE USE DISORDERS, EASTERN MONTANA RESIDENTS, MONTANA HOSPITAL DISCHARGE DATA SYSTEM, 2010-2014

PRIMARY PAYER	Commercial	Medicare	Medicaid	Self Pay	All Other
NUMBER	442	554	543	395	624
PERCENT	17.3%	21.7%	21.2%	15.4%	24.4%

The most common SUD type was alcohol, followed by opioids (Table 3). The number of admissions with opioid SUD increased from 44 to 76 (72%) from 2010 to 2014. Among those admitted for a substance use disorder, 59% were male.

TABLE 3. INPATIENT ADMISSIONS WITH ALL-CAUSE SUBSTANCE USE DISORDERS (SUD), EASTERN MONTANA RESIDENTS, MONTANA HOSPTIAL DISCHARGE DATA SYSTEM, 2010-2014

	Number	Annual Total Charges	Mean Age	Percent Male
TOTAL	2,558	$10,686,062	47.5	59.2
ALCOHOL	1,853	$7,408,497	47.8	65.5
AMPHETAMINES	174	$609,475	36.2	51.7
CANNABIS	227	$705,925	31.1	57.3
COCAINE	10	$52,154	43.8	90.0
DRUG-INDUCED MENTAL DISORDERS	188	$881,119	57.6	42.0
HALLUCINOGENS	9	$19,967	24.9	88.9
OPIOIDS	258	$1,244,956	48.6	39.9
SEDATIVES	29	$92,529	44.5	24.1
OTHER	287	$1,056,958	40.2	45.6

*Admissions with more than one sud are counted in separate categories.

Hospitalizations related to mental health

Twenty-eight percent of all hospital admissions in Eastern Montana from 2010-2014 had at least one diagnosis for a mental disorder (MD). The most common MD was the broad category of screening and history of mental health and substance abuse codes, present on roughly 46% of admissions with codes for at least one MD followed by mood disorders, present on rough-ly 38% of admissions with codes for at least one MD (Table 3). The MD with the lowest mean age was attention-deficit disorders; the MD with the highest mean age was anxiety disorders. The MD with the highest percentage of diagnoses to females was anxiety disorders (65%), the MD with the highest percentage of diagnoses to males was attention-deficit disorders (59%; Table 4).

TABLE 4. INPATIENT ADMISSIONS WITH ALL-CAUSE MENTAL DISORDERS (MDS), MONTANA RESIDENTS, MONTANA HOSPITAL DISCHARGE DATA SYSTEM, 2010-2014

	Number	Annual Total Charges	Mean Age	Percent Male
TOTAL	8,350	$37,375,179	55.4	46.6
SCREENING AND HISTORY OF MENTAL HEALTH AND SUBSTANCE ABUSE CODES	3,877	$20,716,966	57.4	57.6
MOOD DISORDERS	2,756	$10,741,620	52.8	34.9
ANXIETY DISORDERS	966	$3,471,818	60.1	34.6
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	364	$1,049,877	54.0	50.5
SUICIDE AND INTENTIONAL SELF-INFLICTED INJURY	129	$342,335	38.7	51.9
MISCELLANEOUS MENTAL DISORDERS	87	$303,399	51.5	33.3
ADJUSTMENT DISORDERS	66	$184,514	50.8	40.9
ATTENTION-DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS	58	$278,241	32.6	58.6
PERSONALITY DISORDERS	25	$100,692	56.0	44.0

*Admissions are assigned to the single class with the most primary diagnosis. Excludes categories with 20 or fewer admissions.

Acute drug overdose

The analysis on the previous pages does not include hospital admissions for acute drug overdose. In 2014, there were 86 ED admissions and 69 inpatient hospital admissions for acute drug overdose in Eastern Montana. Of those admissions where intent was determined, about two thirds of the inpatient admissions and one third of ED admissions were for intentional self harm. Thus, one third of the inpatient admissions and two- thirds of ED admissions for drug overdose were for unintentional.[14]

There are more than 150 emergency department or hospital admissions annually for acute drug overdose in Eastern Montana.

Suicide in Eastern Montana

From 2010 to 2015 there were 134 deaths due to intentional self-harm injuries in the 17 county region out of 1,433 total in Montana. This averages to around 22 suicides in the region per year. The age-adjusted death rate for intentional self harm in these communities is 28.8 per 100,000 (2010-2015). For American Indians in these counties, the rate for intentional self harm is 59.3 per 100,000 (2010-2015) compared to 21.8 for whites. The rate of death for intentional self harm for men in these counties is 42.9 per 100,000 and for women, 14.0 per 100,000. Compared to Montana, the rates of suicide in Eastern Montana for men and American Indians are elevated.

Death rate per 100,000 population, Intentional Self Harm, 2010-2015

Category	Montana	Eastern Montana
Overall	22.9	28.8
Men	35.3	42.9
Women	10.8	14.0
American Indian	29.2	59.3
White	22.3	21.8
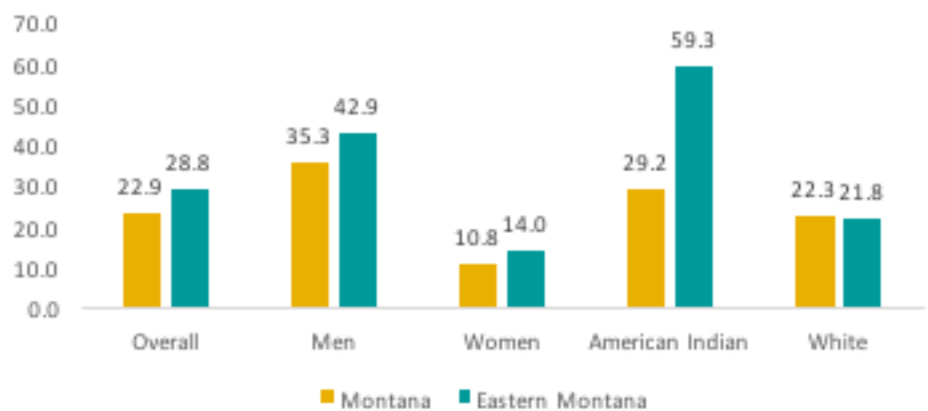
Best practice models for regionalized crisis response and jail diversion in rural areas

To better understand how Eastern Montana might structure their crisis services, we identified examples from other states that have successfully developed regional crisis mental health services in rural/frontier regions. The following pages include case studies based on semi-structured interviews with national, regional and state experts, summarizing their insights and lessons learned.

National organizations

National Association of County Behavioral Health and Developmental Disability Directors

Ron Manderscheid, PhD, serves as the executive director of the National Association of County Behavioral Health and Developmental Disability Directors (NACHBDD). With 40 years of experience working in all aspects of mental health Dr. Manderscheid has extensive knowledge of best practices in behavioral health crisis and jail diversion systems and describes the following as key components of a high-functioning system:

- Crisis Intervention Team (CIT) training for law enforcement
- Intensive case management
- A robust data system that enables warm hand-offs among community partners
- Outreach and enrollment in Medicaid inside of jails
- Respite services for consumers and family members for one day to two weeks
- A restoration/sobering place in lieu of a jail such as a room in a jail or other facility where the primary purpose is to link consumers with services
- Residential or sub-acute care where people can access care for up to 90 days
- Care in an inpatient setting

Key Elements of a Robust Crisis Response System

Ron Mandersheid, PhD
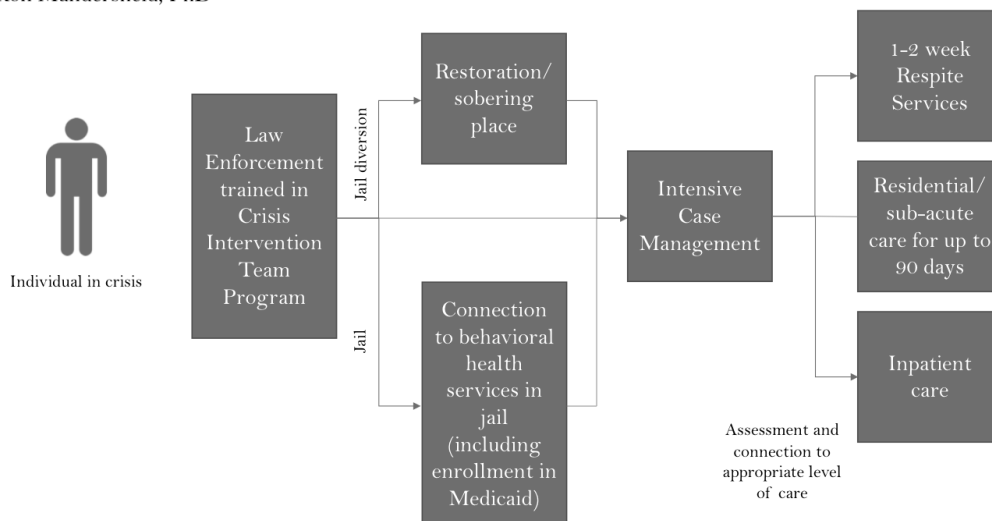
Individual in crisis → Law Enforcement trained in Crisis Intervention Team Program → (Jail diversion) → Restoration/sobering place → Intensive Case Management → 1-2 week Respite Services; Residential/sub-acute care for up to 90 days; Inpatient care

(Jail) → Connection to behavioral health services in jail (including enrollment in Medicaid) → Intensive Case Management

Assessment and connection to appropriate level of care

National Association of County Behavioral Health and Developmental Disability Directors Continued

Dr. Manderscheid is well-aware that not every community, county or region can have all or even most of these components and rural areas in particular, will need to develop unique, innovative, and practical approaches based on their realities and resources. To begin this work, Manderscheid recommends that county leaders join the National Association of Counties' Stepping Up Initiative and pass a resolution to reduce the number of people with mental illnesses in jails.

STEPPING UP

The National Association of Counties, The Council of State Governments Justice Center, and the American Psychiatric Association Foundation have come together to lead a national initiative to help advance counties' efforts to reduce the number of adults with mental and co-occurring substance use disorders in jails. The program involves the following six steps and provides toolkits with resources to support this work:

1. Convene or draw on a diverse team of leaders and stakeholders
2. Collect and review data on the prevalence of people with mental illnesses in jails and assess their treatment needs
3. Examine treatment and service capacity and identify policy and resource barriers
4. Develop a plan with measurable outcomes
5. Implement research-based approaches
6. Create a process to track and report on progress

Two Montana counties, Missoula and Lewis and Clark have passed Stepping Up Resolutions.

Two years ago, NACBHDD began a major effort to address this problem with a focus on mid-sized and small, rural counties. The effort began with webinars that introduced the Sequential Intercept Mapping (SIM) model as a method for communities to identify and address their specific problems in terms of the points at which an individual is "intercepted" by various parts of our behavioral health and criminal justice system as shown below.

A number of participating counties were then selected for further and deeper technical assistance, based on the level of participation and engagement they demonstrated from critical players – law enforcement, county commissions, courts, corrections, behavioral health, hospitals, health departments, human service agencies and so forth. These counties focused on addressing problems in the areas of Intercepts 1 and 2 (law enforcement and initial detention/court hearing) and after a year, the association reports many have made significant progress toward solutions.

According to Dr. Manderscheid, a second cohort of counties will be selected for assistance, but based on the experience of the first, this cohort will go further "upstream" and focus on Intercept 0 (services that connect individuals in need with treatment before a crisis or at the earliest possible interaction with the system). Manderscheid also emphasized that, without exception, communities using the model learn that their agencies don't fully understand how their partner agencies operate, and that this realization alone begins forward movement.

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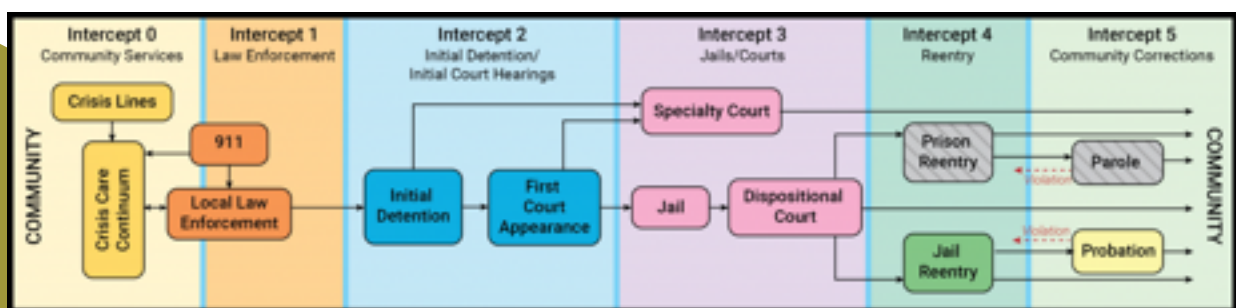
SAMHSA GAINS Center

Dan Abreu, MS, CRC, LMHC, is employed by Policy Research Asssociates, Inc., and serves as a senior technical assistance specialist with SAMHSA's GAINS Center. Through technical assistance to professionals and communities, the GAINS Center is focused on expanding access to services for people with mental health and/or substance use disorders who come into contact with the justice system. In this capacity, Abreu provides assistance to SAMHSA grantees, including helping communities use the Sequential Intercept Model (SIM) (see graphic on previous page).

When asked about crisis intervention and jail diversion models that could work in a vast, frontier area, Abreu noted that it is not possible for any community to duplicate another community's model, but that it is possible to use components from other systems. Abreu advises communities to build on what they already have in place and develop multiple levels of response. Touching on key aspects of each intercept in the SIM, he offered these suggestions.

• EMS are underutilized in terms of mental health calls and crisis response. Mental health training for these professionals is important, as they can make crisis situations better or worse.

• EDs need support from and a close, on-going connection with behavioral health.

• Trained peers are a workforce that could be developed in a rural areas. These peers have been used to "walk through" the ED experience with consumers. Once that contact is established, maintaining it can be helpful to the consumer moving forward.

• Once a person leaves the ED, follow-up within 24-48 hours is critical to assure a consumer is connected with community-based services.

• It is essential to have a close connection between law enforcement and behavioral health and this connection should aim to avoid law enforcement transports, assure officers know how to make referrals, and facilitate "warm hand-offs."

• While CIT can be helpful, the time commitment for training may be difficult for rural areas. Still, rural law enforcement agencies can learn important lessons from CIT such as the necessity of mental health training for law enforcement, the need to engage behavioral health and law enforcement to develop and refine a response model, and the need for stakeholders to meet regularly to work through case studies and refine protocols.

• Maximize the use of a crisis line as the first point of contact. Crisis lines can even be used by the jails to connect prisoners with crisis counseling and assessment.

• Mobile crisis response teams can help to get the most out of the first intercept with law enforcement, but rural areas should maximize the use of phone and video technology.

• Jails should be considered healthcare settings and behavioral health providers should communicate with them as they do any other provider. This is particularly important given the frequency of suicide in the jails.

• Screen for mental illness and substance abuse in the jails using evidence-based screening tools, and engage with behavioral health as soon as possible. One small rural community has developed a simple system to fax a list of prisoners to the community mental health center each morning.

• Screen veterans early in the process of being booked to determine who is eligible for diversion to a veteran's program.

• Enhance communication with the court system. Even without a specialty court it is possible to divert people with mental health issues if there are programs in place that court officials trust.

SAMHSA GAINS Center Continued

• Coming out of jail, timely behavioral health and other community services, connection with benefits, and assurance that necessary medications are available are critical to avoid consumers reverting to substance use and psychiatric flare ups.

• Consideration should be given to assisting high need consumers who repeatedly have crisis events. In small communities, these individuals are often known to multiple agencies. Working with 9-1-1 dispatchers and other responders, it may be possible to better understand the numbers and needs of this population and to put in place supports to avoid repeat events.

Suggestions from Dan Abreu, of the SAMHSA GAINS Center
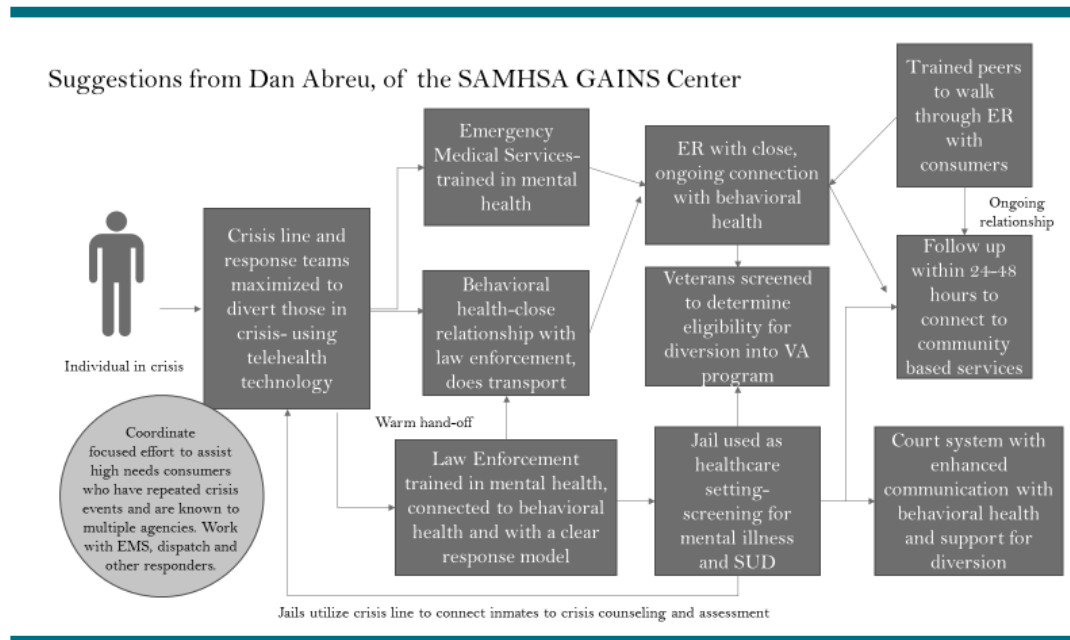
State and regional models
Southeast Nebraska

The state of Nebraska passed legislation in 2004 to downsize the number of state hospital beds and increase community-based behavioral health services with the goal of Nebraskans receiving treatment closer to home, family, and support services. State funding was redirected to create regional crisis services intended to divert clients from state hospital beds and jails, and with the requirement to provide service to any individual in need.

The Regional Behavioral Health Authority used this opportunity to create a crisis system for the sixteen county region in southeast Nebraska that has diverted 84% of its involuntary emergency protective custody placements since its inception in 2005. The region is primarily rural with the exception of Lincoln. Key components of this regional system include:

• Mobile crisis response counselors who assist law enforcement in 40 sheriff's offices and municipal police departments on a 24/7 basis.
• Case managers who provide 24/7 emergency community support beginning with the crisis event.
• Law enforcement officers who have received Crisis Intervention Team (CIT) training.

Southeast Nebraska Continued

There are six mobile crisis response counselors within the region and each is on call two out of every six weeks. While on duty, a counselor covers eight counties. When law enforcement calls the crisis response team, a call may be handled in one of two ways. A counselor may respond face-to-face with a drive that can take up to two hours. Or, if the urgency is deemed by the officer to require a more rapid response, the counselor can provide a virtual crisis response. This is accomplished using iPads equipped with the secure interface, OmniJoin Law enforcement can use this technology with either their onboard or office computers.

While a crisis counselor is working with a client, the client is also connected with emergency community support via a 24/7 case manager. Regardless of where a client is placed following a crisis event, these resource experts begin working with the client during the event and may continue for up to 90 days. The case manager's goal is to assure clients access and stay connected with community services and supports. These services can vary widely. For some, the need might be for gas money to stay with a friend or for an overnight hotel stay. Following a crisis event, services might include treatment with a counselor and/or prescriber, housing, physical health services or support-

ed employment. Many clients are able to remain in their communities or return to their communities more quickly because of this intensive and immediate case management service.

If a client is in need of a voluntary admission to the inpatient psychiatric unit in Lincoln and does not have another means of transport, under certain circumstances a crisis counselor will perform the transport. For those placed in emergency protective custody, there is a crisis stabilization unit in the region specifically for involuntary commitments, and these transports are performed by law enforcement. Travis Parker, MS, LIMHP, CPC, has been a crisis counselor in this system since its inception. Parker says there are two factors that have been critical to the success of the system.

- Crisis counselors are willing to travel to law enforcement, and in some cases provide patient transport. This has been particularly important in this rural region since it is not uncommon for an officer to be the only one on duty in an entire county, especially on third shift.
- Warm hand-offs to case managers are available 24/7 and are part of the initial crisis response. When they have a choice, officers are less likely to take a person into custody when they know there is a plan in place for that individual.

Crisis Response System in Southeast Nebraska
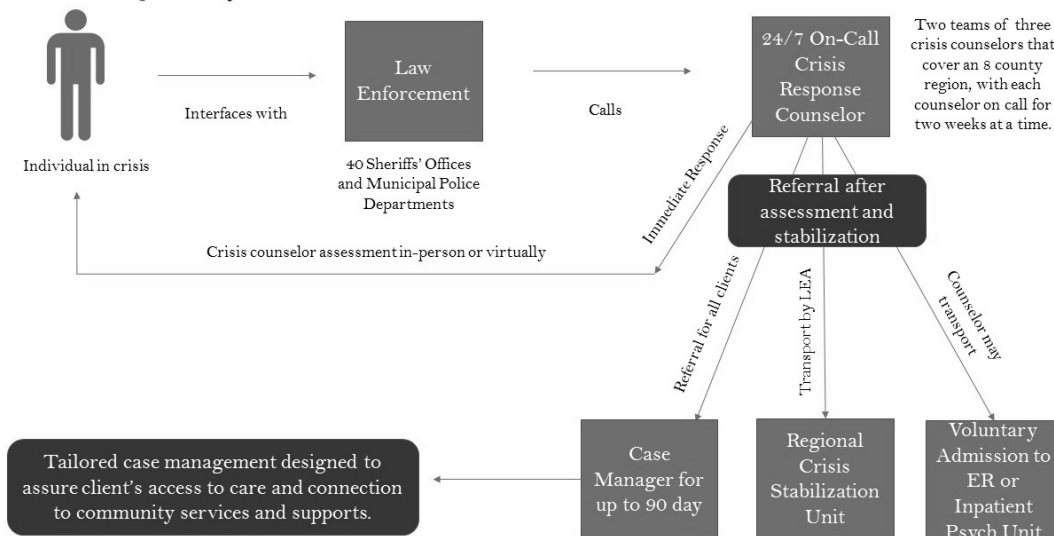
Remote Alaska: Use of paraprofessionals and technology

The Western Interstate Commission for Higher Education (WICHE) Mental Health Program aims to: 1) assist states in improving systems of care for mental health consumers and their families; and 2) advance the preparation of a qualified behavioral health workforce in the West. Dennis Mohatt, Vice President for Behavioral Health at WICHE has assisted states and localities across the West with mental health system development. While he cautioned about trying to directly overlay models for crisis intervention from one area to another, he offered valuable insights from his work in various locations, especially Alaska.

Use of trained paraprofessionals to provide basic primary care and dental services in remote Alaskan villages is widespread, and this concept is now being used in behavioral health. Behavioral health aides are trained to provide case management, routine care and support, and to help people stay on medications and intervene during mental health crises in these villages. According to Mohatt, for any rural and remote area, "it is important to train local people to be able to assess and resolve crises and refer. But, there has to be some 'boots on the ground,' some capacity to respond. That is what these aides provide."

The state of Alaska has created a statewide "health hub," that provides telehealth capacity to remote areas. This technology allows behavioral health aides and other paraprofessionals to be supported by professionals in larger communities. This technology also allows patients to be seen without professionals ever traveling to the villages. If a situation becomes too difficult to handle locally, patients are transported for acute care services in larger communities or to the state hospital in Anchorage. The state hospital has also arranged for a robust telepsychiatry program to reach out to villages to provide medication checks.

Mohatt described the behavioral health aide as something along the lines of a community health worker, home visitor or a community mental health professional extender. He said the model may have some relevance to rural areas with more roads than in Alaska, but that Medicaid would have to allow for billing of services to make it work.

The examples of use of paraprofessionals supported with technology are many, according to Mohatt. The military uses platoon level medics to perform behavioral health assessments, and high end technology to connect people in the field with hospital settings. Also in Alaska, he described a project that involved the state hospital and a rural community, in which case managers were given iPads to interface with people in crisis and receive consultation from state hospital professionals. But key to the success of any technology is the training. Mohatt said he has "been in many rural clinics that had dusty video hookups in the corner."

Crisis Services in Remote Alaskan Villages
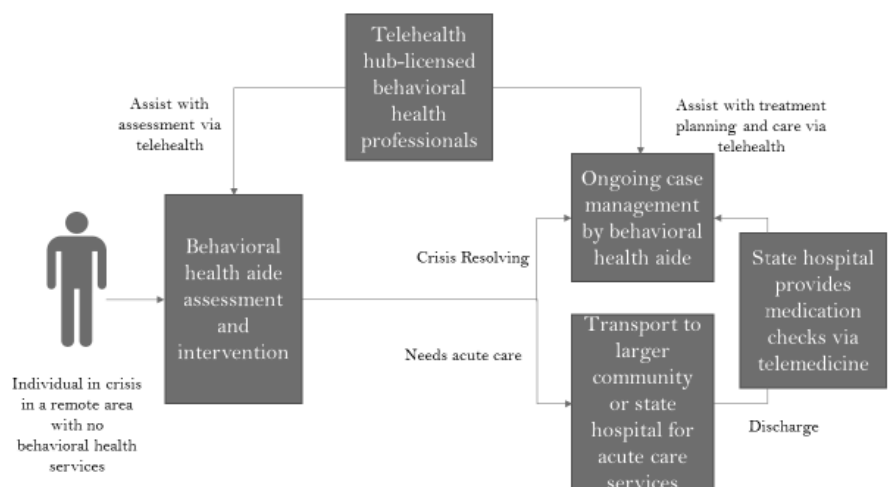
Remote Alaska Continued

When asked about key elements to shore up behavioral health services in extremely rural areas, Mohatt offered the following for consideration.

- Train all responders in Mental Health First Aid (MHFA)
- Train those most interested in CIT
- Train and support place-committed people, rather than trying to continuously recruit for behavioral health professionals that you must convince to move to and stay in your community
- Maximize the use of mid-level providers supported by telehealth, even in inpatient settings
- Consider the use paraprofessionals and EMTs with supports, but know that reimbursement will be necessary

Missouri

After the Sandyhook school shootings in December 2012, then Missouri Governor Jay Nixon decided he wanted to strengthen Missouri's mental health system. According to Rick Gowdy, Director of the Missouri Division of Behavioral Health, the Governor directed the Missouri Department of Mental Health to develop Missouri's Strengthening Mental Health Initiative and provided $10M toward its development. The Governor asked that a proposed approach be developed in time for his State of the State Address in January 2013, and in time to request additional funding from the legislature that winter.

Missouri's Strengthening Mental Health Initiative includes three major components:

1. Community Mental Health Liaisons (CMHLs) are trained behavioral health professionals that are dedicated to support law enforcement and courts,

2. Emergency Room Enhancement personnel (EREs) are trained behavioral health professionals that are dedicated to support hospital emergency rooms, and

3. A robust statewide CIT initiative.

In partnership with Community Mental Health Centers (CMHCs), the state created 31 CMHL positions that cover 114 Missouri counties. These individuals are mental health professionals employed by the CMHCs who only take referrals from law enforcement and the courts. They are expected to be available during business hours, provide on-site mobile crisis counseling and assessment, and connect consumers with services. The CMHLs work in any location they are needed - people's homes, jails, at law enforcement staffing meetings and occasionally they ride along with law enforcement. If an event occurs when they are off duty, law enforcement or the court can make a referral for services to be provided the next day. CMHLs follow each consumer for 30 days and assure clients, who are often high service utilizers, don't fall through the cracks. Gowdy said when consumers don't show up for appointments, CMHLs will go to their homes or if they are homeless, will find them and find out what is happening in their lives.

Sgt. Jeremy Romo is an officer with the St. Louis Police Department and Director of Missouri's statewide CIT initiative called the Missouri Statewide CIT Council. According to Romo, "CMHLs are the best thing that ever happened to law enforcement." Romo said that while it may be ideal to have mental health professionals who are dedicated to ride along with law enforcement as is done in large cities, the CMHL approach is more realistic and doable even in smaller jurisdictions. He reported this approach is working, as they have seen a dramatic decrease in crises among people who previously had repeated events.

Similarly, EREs are mental health professionals that are dedicated to assisting in emergency rooms in seven areas of the state, some of which are rural. This has resulted in fewer admissions to hospitals and greater attendance in treatment according to Gowdy.

Before the Strengthening Mental Health Initiative, Missouri had a significant effort toward CIT, according to Gowdy. With the Initiative, the state built on this by creating the Missouri CIT Council. The initiative is led by Sgt. Romo, who is employed as the state CIT coordinator while remaining a commissioned officer with the St. Louis Police Department. According to Gowdy, for credibility with law enforcement, it is important to have commissioned, uniformed law enforcement lead this effort. Within one year of having the CIT Council, the state went from 22 local CIT Councils to 37, and attendance at the statewide annual CIT conference grew from 300 attendees to 450. While CIT started in some of Missouri's larger areas, Romo is now charged with working to reach rural areas.

"Collaboration is the most important part of the work," Romo said. "There is so much liability involved in police work that mental health training is really important now." He said that he believes among some officers mental health stigma may be exaggerated due to their interactions with people during crises and the misperception that people with mental illness are often or always in crisis. The officers who are most against the training initially, often find it the most valuable and rate it the highest by the end of the training, according to Romo. Romo said having a local multi-discliplinary CIT Council is the way to operationalize this collaboration. It provides a forum for behavioral health, law enforcement, medical and other professionals to work through system issues and develop protocols.

Missouri Crisis Response
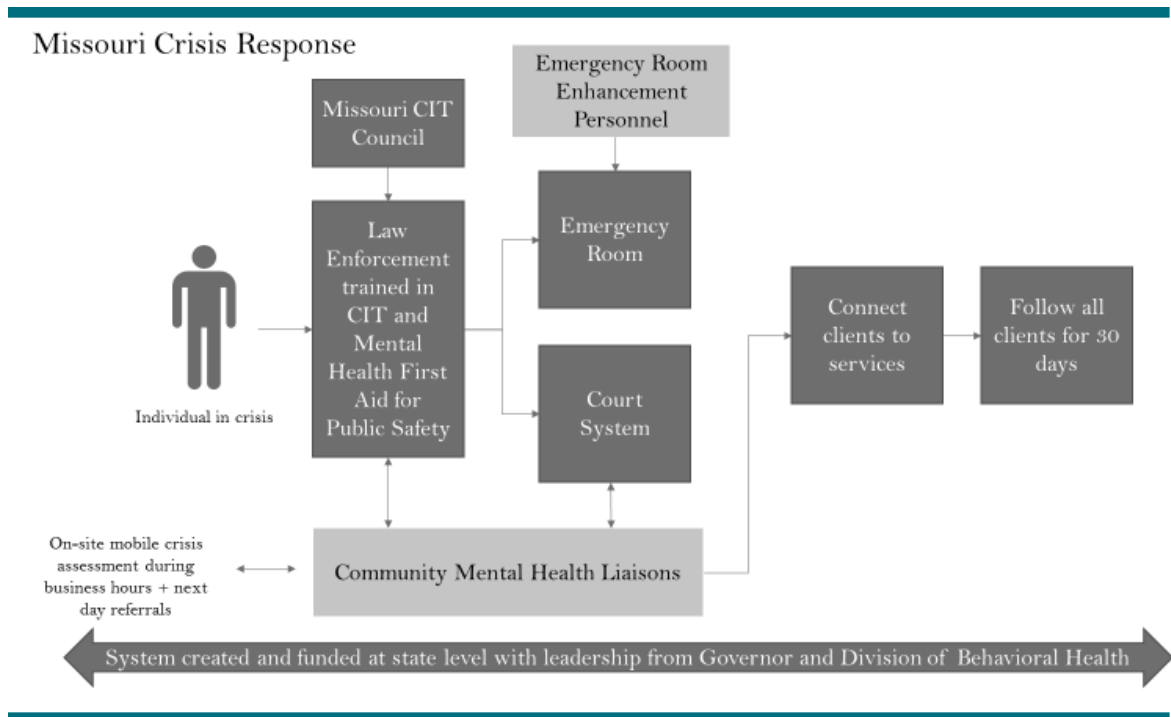
Missouri Continued

When asked how to deal with crisis response issues faced by very rural and frontier regions, Romo offered that the International Association of Chiefs of Police One Mind Campaign may be helpful.

The International Association of Chiefs of Police One Mind Campaign seeks to ensure successful interactions between police officers and persons affected by mental illness with four strategies outlined in the inset box. Gowdy stressed that with the exception of a few popu-

INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE ONE MIND CAMPAIGN STRATEGIES

- Defined, sustainable partnership between law enforcement and community mental health
- Policy addressing police response to persons affected by mental illness
- Training for 100% of an agency's sworn officers and selected non-sworn staff, such as dispatchers, in Mental Health First Aid for Public Safety; and
- Training for 20% of an agency's sworn officers and selected non-sworn staff, such as dispatchers, in CIT.

lation centers, Missouri is primarily rural. He offered that Missouri has also developed seven or eight 1-2 hour mental health training modules for law enforcement and associated personnel such as dispatchers, that are accredited by the state's peace officer training board. CMHLs provide these trainings to law enforcement agencies at no charge. According to Gowdy, these have been well received and have helped to establish the relationship betwen the CMHLs and law enforcement. In addition, Gowdy said the state of Missouri leads the nation in people trained in Mental Health First Aid, and several areas have joined and are using NACo's Stepping Up Initiative.

Gowdy said all CMHCs are required to have crisis hotlines and some contract with a couple that are available statewide. He reported that while many of the larger areas have mobile crisis response teams, in some areas of the state law enforcement officers carry iPads and connect consumers with mental health counselors using Skype. He said this is offered voluntarily due to real or perceived confidentiality issues, but that nearly everyone agrees to the offer.

Idaho Regional Crisis Services

Over a seven year period, the state of Idaho observed an increasing number of involuntary mental health holds by law enforcement, while civil commitments remained flat over the same period. Many of those put on hold were spending time in emergency departments and jails, but did not meet criteria for commitment. Using the SIM Framwork to guide the discussion, the state convened relevant stakeholders to work on solutions to this problem. The group recommended crisis centers be developed in seven regions that cover the state's 44 counties. This solution was supported by the Governor and in 2014, the Behavioral Health Crisis Centers Act was passed by the Idaho Legislature. Key features of this legislation include that these Centers:

- reduce unnecessary incarcerations, hospitalizations and emergency department use,
- are available on a short-term and voluntary basis to any Idahoan experiencing a crisis without regard to insurance status, and
- are locally governed.

The state provided funding to establish these centers, but required that the centers have a plan after two years to reduce the state's commitment by 50% over the following two years.

Idaho Regional Crisis Services

The state contracts with various entities to operate these regional facilities. For example, in Idaho Falls, funding is provided to Bonneville County and the county contracts with a private behavioral health care provider, Rehabilitative Health Services (RHS), to operate it and with local law enforcement to provide security. In Coeur d'Alene, the state contracts with Kootenai Health, the major health system in the region that also provides emergency room services and inpatient psychiatric services, to operate the regional crisis center. Not every region has operationalized a center and one is considering an alternative solution (see the section on Idaho Region 2 Rural Crisis Stabilization Project).

- Ross Edmunds, Mental Health Commissioner for the State of Idaho, reports that the centers are having positive and measurable impacts. In the region that includes Idaho Falls and Pocatello, the crisis center is estimated to have saved $750,000 in emergency department costs by the end of its first year of operation, and the region saw its number of involuntary mental health holds flatten rather than increase. The center in Coeur d'Alene estimated a 25% reduction in emergency department usage due to mental illness and inpatient psychiatric hospitalizations in its first year.
- The state of Idaho provides state-funded outpatient behavioral health services for indigent clients through seven state-run regional offices, but contracts for Medicaid services with the exception of those for very high needs clients who are also served by the regional offices. State and county funding is used to pay for indigent clients' medical care, including behavioral health care – with counties paying for events costing less than $10,000 and the state picking up the higher cost events. While Medicaid mental health providers are reimbursed on a fee-for-service basis, the state contracts with Optum, a managed care company, to manage and pre-authorize outpatient services (excluding pharmacy). Only ten hours of crisis services per year can be pre-authorized.
- Edmunds said the challenge now will be working on the sustainability plans for these centers. Key issues he raised were working to get more coverage from Medicaid and private insurance, and ensuring counties realize savings in indigent care dollars by using the centers.
- Edmunds said Idaho has mobile crisis teams in population centers, but that coverage in rural areas is limited. The CIT training initiative in Idaho is robust according to Edmunds, and the work underway on slowing recidivism and incarceration rates is good. When asked for advice for a frontier area, he said, "there is no magic advice other than getting stakeholders to commit to work together across disciplines, to stay at the table even when there are disagreements, and create opportunities that fit."

Behavioral Health Community Crisis Center of East Idaho

While there are now several regional crisis centers, this effort began with a pilot project located in Idaho Falls that serves 17 Eastern Idaho counties that are primarily rural with the exceptions of Idaho Falls and Pocatello. The Behavioral Health Community Crisis Center of East Idaho is a 20-bed facility that provides voluntary, 23 hour 59 minute stays (in part, to avoid certain licensure requirements for facilities that allow longer stays).

Staffing includes 24/7 nursing services. All clients are assessed and if clients are deemed medically stable, they are voluntarily admitted. Bachelor's level social workers staff the center during the day and "psych techs" are on duty 24/7. DeVere Hunt

Behavioral Health Community Crisis Center of East Idaho Continued

of RHS is a master's level clinician that provides clinical supervision. A master's level clinician is also in the center once per week to work with clients with substance abuse issues. Hunt estimates that 50 to 60% of clients have a substance abuse history in addition to a mental illness. An amnesty box allows clients to dispose of drugs and paraphernalia at the center with no questions asked.

Clients can be walk-ins, can come with family or friends, are referred by local providers, often as an alternative to the emergency department, and an estimated 40% are brought to the center by law enforcement. At the center, clients receive mental health assessments and are linked to services in the community. While a goal of the center is stabilization, and the center is technical-ly for 23 hour 59 minute stays, clients are often discharged and readmitted, allowing them to be there three to five days. Nine beds are organized in each of two rooms, with two additional single rooms. Clients can come and go as they please, however, those who are a threat to themselves or others are put on holds by law enforcement.

The region has CIT trained officers including those contracted for security in the center. The center works closely with law enforcement and has offered an alternative to incarceration for those who would previously have been charged with lesser crimes such as trespassing and disorderly conduct. Additional crisis services in the region include a 24/7 crisis call center and separate transitional residential homes for men and women.

Idaho Region 2 Rural Crisis Stabilization Project

The Regional Behavioral Health Advisory Board in Idaho's Region 2 has determined that the regional crisis center model is not workable due to the rural nature of the region (the exception being the Moscow and Lewiston area). According to Region 2 Program Director Joyce Lyons, this five county region touches the Washington and Montana borders and reaches north nearly to Coeur d'Alene and to south almost to McCall.

The Board is proposing to the state of Idaho that it develop crisis stabilization rooms in five critical access hospitals to allow these services to be delivered in a more local manner. Crisis stabilization services would be available 24/7 for individuals who present to the emergency departments (ED) in these hospitals both voluntarily and involuntarily. Regional behavioral health crisis stabilization teams would be created by drawing on the staff of existing organizations. The teams would include behavioral health clinicians, certified nursing assistants, psych techs, security and transporters. The idea is for these individuals to provide "just-in-time" services. All team members would receive training in Mental Health First Aid, Management of Aggressive Behavior, and Crisis Assessment and Treatment/Safety Planning. ED staff would be a part of the team and would play an integral role in stabilizing clients.

Once seen by the ED, if a client is in crisis, a behavioral health clinician that is part of the regional team would be called. Key components of the crisis stabilization services that would be available as needed from these teams include:

- medical stabilization – ED staff
- crisis assessment including diagnostic evaluation, mental status exam and risk assessment – regional crisis clinicians
- crisis therapy and treatment/safety planning – regional crisis clinicians
- safety observation – ED staff (CNA/tech)
- security – Sheriff's department or designee
- transportation (as needed to/from inpatient psychiatric hospital) – Sheriff's department or designee

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Funding for this plan would be a combination of billing Medicaid and private insurance when available for hospital services, behavioral health assessments, case coordination and face-to-face therapy. In addition, funding is provided by the state to the Regional Behavioral Health Board for crisis stabilization services (used for crisis centers in other regions) and would be used to support this project through contracts with the hospitals for development of rooms that are safe and secure, and provide for 1:1 observation. This funding can also be used for services provided to clients without healthcare coverage, for law enforcement agencies or their subcontractors to provide security and transport services, and for training of the teams.

The more populated area in this region includes Lewiston and Moscow in Idaho, and Clarkston and Pullman in Washington. This region is not pursuing a crisis center or the local crisis stabilization model described above, as it already has an inpatient psychiatric hospital and a recovery center, that supports individuals with substance use disorders (SUD) and co-occurring SUD and mental health issues.
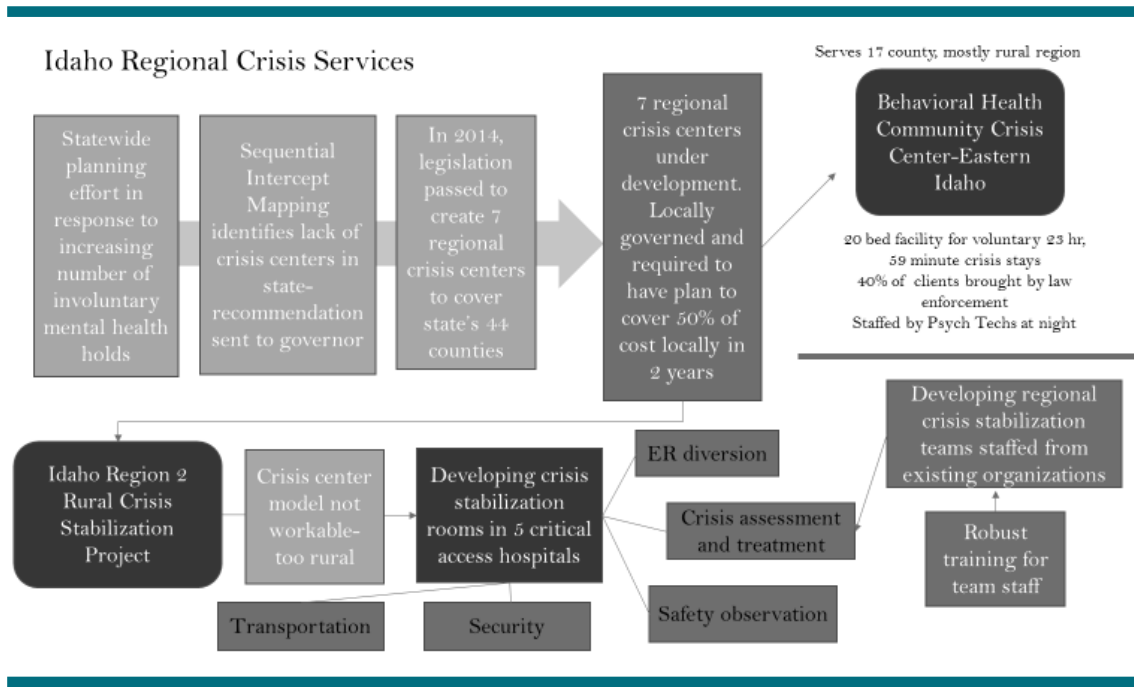
Rural Oregon: Lifeways

The state of Oregon has pioneered crisis intervention and jail diversion services. Regional Coordinated Care Organizations (CCOs) manage the state's Medicaid program and subcontract for mental health services with counties who are the local mental health authorities. The counties either provide services for Medicaid beneficiaries and indigent consumers directly, or contract with private entities to do so. Either way, counties are responsible as the mental health authority and manage Medicaid services on a capitated basis including being at-risk for acute care services. Contracts with the CCOs disincentivize the use of higher levels of care and incentivize development and use of community-based options by providing innovation funds that are based on performance.

Rural Oregon: Lifeways

With this funding mechanism, many rural counties have been able to develop crisis intervention and jail diversion services. For example, Lifeways is the community mental health program for two rural counties in Eastern Oregon with a population of approximately 100,000. The Lifeways crisis intervention and jail diversion initiative in this area is robust and includes:

- Use of Sequential Intercept Mapping as a planning tool
- A 24/7 crisis hotline, with ProtoCall Services answering after hours. ProtoCall Services, is a nation-wide service that provides telephonic crisis assessment, intervention, and stabilization by masters and doctoral-level clinicians.
- Mobile crisis teams
- Crisis Intervention Team (CIT) trained law enforcement, memoranda of understanding with law enforcement agencies, and regular joint meetings among law enforcement and behavioral health staff to discuss protocols and other issues.
- Co-location of behavioral health staff in a hospital emergency department
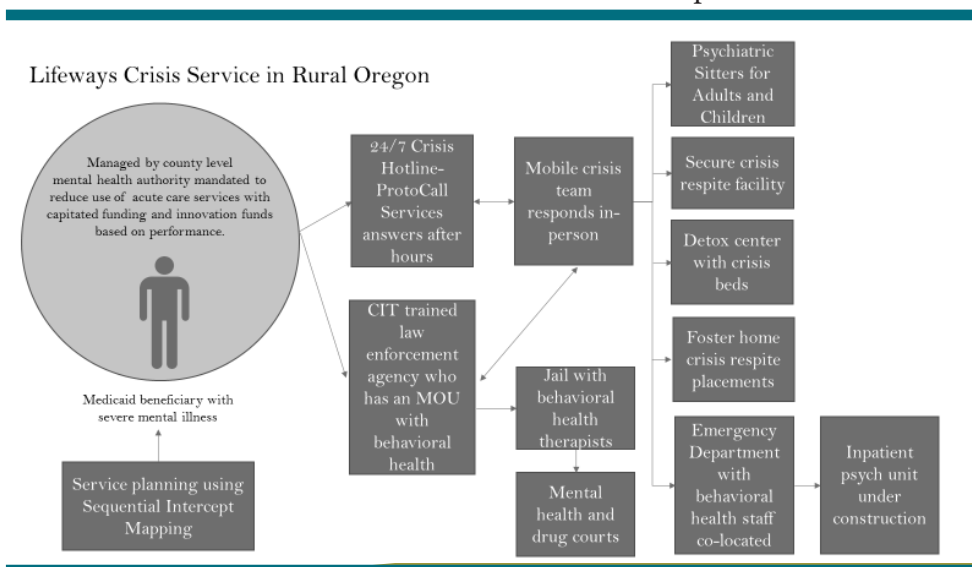- A crisis respite center and crisis beds in both a secure facility and a detox facility
- Foster home crisis respite placements
- Psychiatric sitters for adults and children
- Behavioral health therapists who spend time in the jails to work toward shorter stays, reduced recidivism, and to ensure treatment continues upon release
- Problem solving courts, including a mental health and drug court
- An inpatient psychiatric unit is under construc-

tion in this region, again with the goal of providing service closer to home and to avoid longer transports

Ray Millar, COO of Lifeways says his region has also invested in primary care settings and ensuring that providers have training to screen for substance abuse and mental health issues and to refer timely to appropriate services. Millar says two keys to jail and hospital diversion are: 1) having a strong continuum of outpatient services that prevent crises, such as assertive community treatment, outpatient wraparound services, intensive case management and peer supports; and 2) having settings to which people can be diverted. Based on his extensive experience in behavioral health in many roles, Millar offered the following insights into helpful approaches to crisis services and jail diversion in rural areas:

- use of telehealth for crisis response and psychiatry services
- behavioral health support 24/7 provided to hospitals and law enforcement
- mental health training for law enforcement and regular communication between law enforcement and behavioral health professionals
- a basic place to keep a person in crisis overnight, perhaps staffed with a paraprofessional or nurse with a master's level behavioral health professional consulting remotely
- reaching agreement regarding a balanced approach to jail diversion from prosecutors and defense attorney, and securing MOUs among behavioral health, law enforcement, probation and parole, and the courts is helpful.

Lifeways Crisis Service in Rural Oregon

Managed by county level mental health authority mandated to reduce use of acute care services with capitated funding and innovation funds based on performance.

Medicaid beneficiary with severe mental illness

Service planning using Sequential Intercept Mapping

24/7 Crisis Hotline- ProtoCall Services answers after hours

CIT trained law enforcement agency who has an MOU with behavioral health

Mobile crisis team responds in-person

Jail with behavioral health therapists

Mental health and drug courts

Psychiatric Sitters for Adults and Children

Secure crisis respite facility

Detox center with crisis beds

Foster home crisis respite placements

Emergency Department with behavioral health staff co-located

Inpatient psych unit under construction

Oregon Crisis Intervention Teams Center of Excellence

In addition to a funding mechanism designed to drive use of community-based services and avoid hospitalizations and incarcerations, the state of Oregon has provided support for communities to develop and sustain crisis and diversion services. A new Crisis Intervention Teams Center of Excellence (CITCOE) is providing assistance to communities to implement CIT and SIM. Carol Speed, Criminal Justice Behavioral Health Manager with the Greater Oregon Behavioral Health Initiative, is one of four principles providing part-time staffing to the CITCOE – two principles are behavioral health professionals and two are law enforcement officers. Speed and her colleagues are taking a community-driven approach to assist communities to innovate with these tools to fit their needs, including making them relevant for rural areas.

SIM is a method for communities to identify and address their specific problems in terms of the points at which an individual is "intercepted" by various parts of our criminal justice system. Speed reports that the response to SIM has been positive. The experience increases collaboration and the report that is produced from the mapping exercise becomes a strategic plan for communities to work on their systems. Speed says that she has experienced skepticism about the applicability of CIT in rural areas. The "gold standard" CIT Model was first developed in Memphis, TN and includes some core elements:

- A week-long (40 hour) of training for law enforcement to assist them in more effectively managing crisis events when they encounter individuals experiencing a behavioral health crisis, with a goal of having 20% of an agencies' officers trained. Advanced training is also available.
- A community partnership or council that includes behavioral health and human service providers, law enforcement, consumers and their families, and that is focused on increased safety for law enforcement and consumers.
- A strong working relationship between behavioral health and law enforcement and a "no wrong door" philosophy for facility-based crisis services.

The CITCOE is making this model more workable for rural areas by bringing technical assistance to them to deliver the training in their own communities. Communities are laying it out in various ways, with some communities providing the training one day per week for three weeks and then two days back to back for the fourth week. This allows them to spread out the training, rather than taking officers out of duty for an entire week. CITCOE strongly encourages that communities maintain the scenario-based aspect of the training. They are finding the SIM process is a good fit with CIT, and encourage communities to have the plans resulting from SIM "live" with the CIT councils. Speed says this is, "a point in time that a majority of counties are shifting their thinking. These tools bring people together, they keep talking and coming up with ideas. They will continue to trouble-shoot and figure out what works for their communities."

Policy, funding and reimbursement for behavioral health crisis and jail diversion services

Statutes, administrative rules and funding related to crisis and jail diversion

Behavioral health crisis intervention, jail diversion and 72-hour crisis stabilization services are addressed in Title 53, Chapter 21, Parts 12 and 14 of Montana Code Annotated (MCA).[15] While the law allows for county sheriffs to divert to crisis intervention programs, it does not require any entity(ies) to develop and deliver those services. The current mental health system seems to assume there is incentive for county governments to have these services available to help avoid commitment-related costs, and for the state to avoid MSH admissions and other expensive acute care services. However, it is solely at the discretion of local governments and/or health service providers to decide what crisis services, if any, to put in place. Organizations that choose to provide these services must navigate a piecemeal array of funding and reimbursement to support them.

The only mandated crisis service is articulated in the Administrative Rules of Montana (ARM), Title 37, Chapter 106, Rules 1906 and 1945 which require mental health centers to provide crisis telephone services to their own clients 24 hours a day, seven days a week as a condition of licensure.[16] Beyond crisis telephone services for licensed mental health center clients, there are no requirements that any entity(ies) provide any other crisis response services.

Specific requirements regarding provision of crisis telephone services are delineated in ARM 37.106.1945. Mental health centers must employ or contract with "appropriately trained individuals" who have received specific training and instructions. In addition to crisis and assessment techniques, the ARM requires training in the Center's crisis policies,

process for voluntary and involuntary hospitalization, and utilization of community resources.

Jail diversion and crisis intervention are addressed in Title 53, Chapter 21, Part 12 of MCA which requires screening of inmates in county jails to identify those accused of minor misdemeanors who appear to be suffering from mental disorders and who may require commitment for treatment.[17] These statutes allow the sheriff or designee to divert persons to crisis intervention programs, and articulate that crisis intervention programs must provide 24-hour emergency admission and care of persons suffering from a mental disorder that require commitment in a temporary safe environment as an alternative to jail. The law also allows for specific types of jail diversion and crisis intervention services to be provided, and for funding or reimbursement through four mechanisms as follows.

- Medicaid reimbursement
- County matching grant funds
- Secure crisis detention beds
- Short-term inpatient treatment services in lieu of involuntary commitment

In addition, the Goal 189 funds and the Section 1115 Waiver for Additional Services and Populations (WASP Waiver) can pay for specific, limited crisis services.

Medicaid reimbursement

Medicaid reimbursement for crisis intervention services are available as defined by the Montana Medicaid Program in 53-6-101 according to 53-21-1202, MCA.[18] ARM 37.88.901 (5) defines crisis intervention services as, "a program which provides, in accordance with mental health center license requirements, emergency short term 24-hour care, treatment and supervision in a crisis intervention stabilization facility or other community setting for persons age 18 or older with mental illness experiencing a mental health crisis."[19] Codes available to practitioners include CPT codes 90839 and 90840 which are used to bill for delivery of crisis services.

When considering reimbursement for crisis services it is critical to consider both reimbursement for the acute crisis event and services that may be delivered to avoid crises and/or to continue to stabilize a client after the initial crisis event. Services such as targeted case management and community-based psychiatric rehabilitation and support should be explored for the purpose of providing additional supports. These are not the only service codes that can be utilized for reimbursement of pre- and post-crisis treatment services. Providers should maintain familiarity with the Montana Medicaid Fee Schedule in order to maximize reimbursement.[20]

ARM 37.88.901 through 37.88.909 also outline Medicaid reimbursement for other mental health services.[21] ARM 37.88.901 (1) states, "Mental health services for a Medicaid adult under the Montana Medicaid Program will be reimbursed only if the client is 18 or more years of age and has been determined to have a severe disabling mental illness as defined in ARM 37.86.3503." The Medicaid program reimburses a variety of service provider categories including practitioner services, mental health center services, and case management services.

County matching grant funds

County matching grant funds are described in 53-21-1203, MCA and are designated for crisis intervention and jail diversion services, county precommitment insurance and short-term inpatient treatment costs, with interested counties submitting plans for these services annually after July 1.   Plans must demonstrate that they can reasonably reduce MSH admissions for court-ordered detention and evaluation, and ultimately save state funding. State money is used to match local mental health investments and the matching rate is based on a county's use of MSH in the previous fiscal year, with counties with lower utilization rates receiving an enhanced matching rate. County matching funds used to leverage state funds are mental health-related services, including those provided by public safety and criminal justice personnel. Additional information regarding the county matching grant program is provided in ARM 37.89.1001 through 37.89.1009.[23]

County matching grant funds are available in the amount of approximately $2.1M per year. These state funds are used across the state for training, peer support services, crisis response and stabilization, jail diversion and discharge planning services provided in a variety of settings, as well as other innovative approaches. In Eastern Montana, these funds have been accessed for the following:

- *Valley County created and has maintained a secure crisis room in Frances Mahon Deaconess Medical Center. An August 2016 report detailing use of this room from July 1, 2015 through June 30, 2016, indicated that 16 persons were served.*
- *Richland County uses this funding for a nurse in its jail who assesses behavioral and physical health needs and connects individuals with services. The nurse served 218 persons during the same time period.*
- *Seventeen Eastern Montana counties were funded to create this strategic plan for behavioral health crisis and jail diversion services, and to rebuild and reopen the four   behavioral health unit at GMC.*

Secure crisis detention beds

Secure crisis detention beds are described in 53-21-1204, MCA, a statute allowing DPHHS to contract for psychiatric treatment beds for precommitment services and court-ordered detentions before final disposition.[24] ARM 37.89.1021 indicates that the DPHHS may contract with licensed mental health centers that operate secure crisis stabilization facilities and hospitals, including critical access hospitals.[25]

State funding in the amount of $640,000 per year is available for secure community crisis beds and the state holds contracts with five facilities in Butte, Bozeman, Helena, Hamilton and Polson to provide these beds to avoid transporting individuals to the state hospital for emergency detentions. The state provides a small amount of funding to these facilities during times when all secure beds are empty in order to keep this capacity viable. When the beds are occupied, the facilities bill the appropriate payor, which can include private insurance, Medicaid, Medicare, the Mental Health Services Plan, and the state-funded 72-hour crisis stabilization program.

No services are being provided with this funding in the 17 Eastern Montana counties.

Short-term inpatient treatment services

Short-term inpatient treatment services in lieu of involuntary commitment are described in 53-21-1205, MCA. ARM 37.89.1025 describes contracts for payment of short-term inpatient treatment for up to 14 days. A petition can be filed with the court for a stay up to 19 days if a provider believes a patient will stabilize with these additional days.[27] Eligible providers are licensed mental health centers and hospitals with inpatient behavioral health units. The ARM articulates all-inclusive reimbursement for inpatient behavioral health units of $875 per day and for inpatient crisis stabilization facilities of $575 per day.

Funding for short-term inpatient treatment is available in the amount of $500,000 in state funding per year. These funds are being used by facilities in Butte, Bozeman, Hamilton, and Polson. A hospitals in Billings, Helena and Missoula have also signed a contract to provide these services but have yet to utilize the funds. Reimbursement for short-term inpatient treatment is also available for persons with insurance facing involuntary commitment, however, insured placements tend to have longer stays.

No services are being provided with this funding in the 17 Eastern Montana counties.

72-hour crisis stabilization services

72-hour crisis stabilization services and presumptive eligibility for Medicaid are addressed in Title 53, Chapter 21, Part 14 of MCA.[28]   The law allows for medically necessary crisis stabilization services for up to 72 hours for adults who are experiencing a mental health crisis and who are uninsured or underinsured. This presumptive eligibility program allows providers to begin treating a person without ascertaining their health care coverage status. If a person has private insurance or Medicaid, these third party payors must be billed. If a person is uninsured or underinsured, the state will reimburse the provider.

Providers who utilize these funds must be enrolled as Medicaid providers and must be approved by DPH-HS as a 72-hour provider prior to initiating services. Enrollment involves submitting a one-time only form for approval. For each client receiving services paid by this funding source, the provider must complete an eligibility form, provide an assessment and create a stabilization plan that outlines post-discharge referral and transition activities. Covered services include psychiatric diagnostic interview examination/evaluation, individual and family psychotherapy, medication management and crisis management, including care coordination.

Services can be provided to an individual in protective custody or awaiting trial in a detention facility, but not serving a sentence in a detention facility. Only one crisis event within a 7-day period delivered by a single enrolled provider can be covered with these funds. Services can be provided in emergency departments, but inpatient hospital services are not covered. ARM 37.89.501 through 37.89.541 provide more detail about this program.[29] State funding for 72-hour crisis stabilization funds are available in the amount of $2.1M each year.

No services are being provided with this funding in the 17 Eastern Montana counties.[30]

Goal 189 funding

Goal 189 funding is available in the amount of nearly $300,000 per year. This state funding was established in 2008 with a goal of reducing the MSH population to 189 patients by targeting funds to people who have previously been admitted to MSH and are in danger of being readmitted or who are re-entering communi-ty services. Services have typically included payment for housing, medication costs, and living expenses. While these funds are not specifically for crisis services, they can be used to avoid readmission to the state hospital for persons at risk.

EMCMHC provides some services with this funding.

The WASP Waiver and Mental Health Services Plan

The WASP Waiver is addressed in ARM 37.89.103 through 37.89.125. Eligible individuals are those 18 years or older with SDMI, who qualify for, or are enrolled in the state-financed Mental Health Services Plan (MHSP), but are otherwise ineligible for Medicaid benefits and either:
- have income 0-138% of the FPL and are eligible for or enrolled in Medicare, or
- have income 139-150% of the FPL regardless of Medicare status.

The program provides a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income. Rules regarding reimbursement are primarily aligned with Medicaid require-ments, restrictions, limitations, rates, and fees. In the past, this waiver has been called the Health Insurance Flexibility and Accountability Waiver (HIFA).

The Mental Health Services Plan is a state funded program that was historically designed to cover adults in need of mental health services who did not qualify for Medicaid. With passage of the HELP Act, the vast majority of these individuals are now eligible for Medicaid. Thus, the Mental Health Services Plan currently covers less than one dozen participants who are mainly in detention centers amd it, in essence, being phased out. Individuals in detention centers are ineligible for Medicaid, so these funds can be utilized to cover limited psychiatric, prescription drug and mental health therapies.

Overall reimbursement for crisis services

Eligible codes for crisis service reimbursement vary across funding streams. The following table summarizes code availability across the funding streams. It is not meant to be a comprehensive list, rather a brief overview of primary crisis service related codes. Full detail on coding is provided in Appendix A.

Code	Overview	Medicaid Practitioner	Medicaid MH Center	Medicaid Case Management	MHSP Practitioner Services	MHSP MH Center	MHSP Case Management	72 Hour Crisis Intervention	72 Hour CC, CPTS, & Crisis Management
90832	Individual service used for crisis services < 30 minutes							X	
90839	First 30-74 minutes of crisis service	X			X			X	
90840	For each 30 minutes of crisis servic after using 90839	X			X				
H2011	Care coordination								X
T1016	Case management services (must comply with ARM rules)			X			X		
H2019	Community-based psychiatric rehab and support		X			X			X

Workforce and Training Issues

Behavioral Health Providers

Workforce shortages and a vast, sparsely populated region make it difficult to provide behavioral health services in 17 Eastern Montana counties, and can be an impediment to achieving facility licensure. All 17 counties are designated as Mental Health Pro-fessional Shortage Areas by the Health Resources and Services Administration.[31] The impacts of this workforce shortage are costly to the state, region, communities and consumers.

LICENSED BEHAVIORAL HEALTH PROVIDERS IN 17 EASTERN MONTANA COUNTIES, BY COUNTY OF RESIDENCE, 2017

Type of provider	Total in 17 counties
Licensed clinical professional counselors	40
Licensed addiction counselors	33
Licensed clinical social workers	27
Licensed clinical psychologists	7
Licensed marriage and family therapists	3
Licensed psychiatric nurse practitioners	2
Licensed physician assistants with BH	1
Licensed psychiatrist	1
Total	**104**

Montana Department of Labor and Industry and Montana Medical Association, 2017

Among the providers in Eastern Montana, ten are dually licensed -- six for addictions and mental health, four with two mental health licenses. In addition, there are eleven addiction counselor candidates and nine professional candidates (LCPC, LCSW, LMFT) living in the region, bringing the total number of licensed providers to 124. There is ample evidence that the number of licensed providers in Eastern Montana is not adequate to meet the behavioral health needs of the region. For example, a recent analysis by DPHHS found that 15 additional Licensed Addiction Counselors would be needed to meet the demand for SUD treatment in the region.[32]

DISTRIBUTION OF LICENSED BEHAVIORAL HEALTH PROVIDERS IN 17 EASTERN MONTANA COUNTIES, 2017
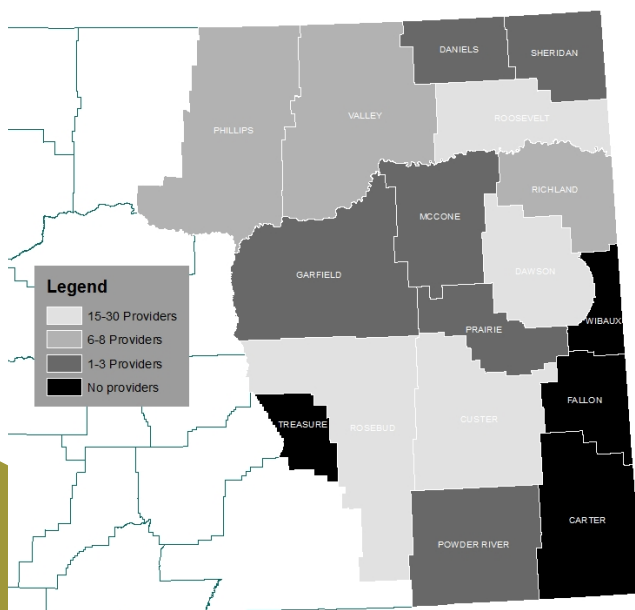
Source: Montana Department of Labor and Industry and Montana Medical Association, 2017

Licensed behavioral health providers are not distributed in proportion to the population living within each county in the region. Four counties in the region have no licensed behavioral health providers, and 77% of the providers in the region live in counties that comprise 47% of the region's population.

Law enforcement officials surveyed in the region report that almost 60% of their calls are related to substance use. Montana statute has historically limited the number of state approved substance use disorder treatment providers in a geographical area to essentially one per county. Without becoming a state approved treatment facility, providers cannot access Medicaid reimbursement or other key sources of funding such as federal Substance Abuse Prevention and Treatment funds distributed at the county level.

The unmet need for substance use disorder services has been well-documented.[33] In response to this need, House Bill 95 passed the 2017 Montana Legislature will go into effect July 1, 2017, and will allow additional facilities to be established.[34] In addition, DPHHS is developing an online substance use disorder training that will enable behavioral health providers licensed in other categories to receive SUD training. With this training, they can then petition the Board of Behavioral Health to become licensed for addiction services and bill Medicaid for SUD services. This also holds potential to expand SUD treatment capacity in the region.

According to the Kaiser Family Foundation, in Montana only 25% of the need for psychiatry is currently met.[35] There are only five states in the U.S. with a lower proportion of needs currently being met. Not surprisingly, there is only one licensed psychiatrist living in the 17-county region. That psychiatrist along with three mid-level providers leave the region with a high need for prescribers.

Behavioral health providers in the region were also surveyed and reported being in their current position for an average of nine years, and one-third reported working in behavioral health in Eastern Montana for more than 15 years. While this level of experience brings a workforce with considerable expertise, it may also signal an aging workforce with even greater recruitment and retention issues on the horizon.

When asked what brought them to the area, 78% of respondents reported they already lived in the area, previously lived in the area or came for family. Only 22% reported they moved for their job. When asked what keeps them in the area, 72% selected "family" and 22% reported being in a loan repayment program. Respondents suggested placing an emphasis on developing staff from local people invested in the area and providing loan repayment opportunities as strategies to improve recruitment and retention efforts, along with increasing salaries and benefits and improving work life balance.

Eastern Montana's federally designed Health Professional Shortage Areas allow certain facilities to be National Health Service Corps approved sites that can leverage loan repayment programs for recent graduates in medicine and certain mental health disciplines, such as master level social workers. The state of Montana also provides financial incentives to practitioners who work in rural and frontier areas. Senate Bill 283, passed by the 2017 Montana Legislature, revised the Montana Rural Physician Incentive Program to increase loan repayment amounts for physicians willing to practice in medically underserved areas or to provide care to medically underserved populations.[36] This legislation, along with federal incentives, could be used to address recruitment challenges in the region.

Peers and Paraprofessionals

As described previously in this report, trained peers and paraprofessionals are a behavioral health workforce being used successfully in other rural areas, including for crisis response and jail diversion efforts. In Montana, the use of peers has been successfully piloted with the Recovery Coach Outreach Program in Gallatin County operated by the Montana Peer Network. This program uses trained peers to provide outreach and recovery support to individuals struggling with behavioral health issues. The peers work primarily with law enforcement, but also receive referrals from other organizations. Once connected with an individual, a peer engages him or her in recovery work, focusing on one of eight dimensions of wellness (using a model developed by SAMSHA) at each visit. Peers in this program work with their referrals for as long as an individual desires. Evaluation of the program indicates that is has successfully diverted individuals from the emergency department, crisis center and jail, and has saved the county $270,000 in crisis dollars in 2016. The return on investment was $4 saved for every $1 invested. This program is funded by Gallatin County with county matching grant funds for crisis and jail diversion services from the state.[37]

While limited reimbursement has historically been available for peer support and recovery services in Montana, Senate Bill 62, passed by the 2017 Montana Legislature will change that. The bill provides for credentialing of peers beginning in October 2017, and is a first step toward allowing Medicaid billing for peer services.[38] The Centers for Medicare and Medicaid Services has allowed billing for peers since 2007, but requires standardized training, documented supervision and coordination of care to ensure that peer support is provided within the context of other services received. Nationally, organizations are working to encourage private insurers to cover peer services. Increased use of peers and paraprofessionals could improve Eastern Montana's capacity to provide behavioral health services, including crisis response and jail diversion services especially in light of the limited number of licensed providers in the region and the workforce recruitment challenges faced by behavioral health organizations. [39]

Primary Care Providers

Primary care providers are on the front lines of screening for and identifying mental health and substance use disorders, and assuring patients are referred for needed treatment services. Sixteen of the seventeen counties in the region are designated as Primary Care Health Professional Shortage Areas by the federal Health Resources and Services Administration, by virtue of having either a geographic area or low income population that is underserved.[40] Four counties in the region – Garfield, Powder River, Treasure and Wibaux – have no licensed primary care providers. Even with limited access to primary care in the region the majority of referrals to high levels of behavioral health care come from the primary care setting. Between 2001 and September of 2014, among 592 admissions to the Glendive Medical Center Behavioral Health Unit, 72% were referred by a physician.

One way that primary care providers could be supported to appropriately assess and refer patients with behavioral health concerns is through training. Some training on screening for depression and suicidality has been delivered to primary care providers in the region in recent years by the state of Montana's suicide prevention coordinator. Little else is known about training in behavioral health among this important provider group.

Law enforcement and Emergency Medical Services

LEAs and EMS personnel are often the first professionals to encounter persons experiencing behavioral health crises. Across the country, there has been a concerted effort to ensure these professionals are trained to assist persons in crisis.   LEAs and EMS surveyed in region report the following with regard to behavioral health training:

- Half of the LEAs reported 50% or more of their officers are trained in Mental Health First Aid (MHFA), with the remainder reporting few or no officers trained in it.
- One EMS respondent reported 100% of staff were trained in MHFA, with most reporting few or no staff trained in it.
- 88% of LEA respondents reported 25% or less of their officers are trained in Crisis Intervention Team (CIT) Training.

The 2017 Montana Legislature passed House Bill 237, creating a CIT Program administered by the Board of Crime Control and intended to coordinate development of CIT teams statewide. The CIT Program is envisioned to provide grants to local jurisdictions for this training.[41]

Telemedicine

Telemedicine or telehealth, services are widely used for psychiatry and behavioral health crisis response in this region. Technology for telemedicine continues to change and the cost of using the technology has decreased with the introduction of secure Internet-based applications and movement away from proprietary "hard-wired" equipment and systems. This offers Eastern Montana opportunities not only to increase behavioral health service capacity, but potentially develop virtual, mobile crisis response capabilities. The opportunity for virtual, mobile crisis is critical because the delivery of in-person crisis services is prohibitive in a region this vast and rural.

Coverage for telemedicine is described in 33-22-138 MCA, and provides that health care plans must cover telemedicine for all services otherwise covered by a plan. Audio-only telephone and email services are not considered telemedicine.[42] There are existing telemedicine networks and infrastructure in Eastern Montana that should be considered as the region plans for how telemedicine might be utilized for crisis services.

Eastern Montana Telehealth Network

Eastern Montana Telemedicine Network (EMTN) operated by Billings Clinic has 17 sites in the region. Providers in Eastern Montana, including behavioral health providers, have pioneered the use of telemedicine with the EMTN since 1993. Through the EMTN, Billings Clinic provides scheduled appointments, clinical consultation and provider education, including psychiatry services provided by 14 psychiatrists employed by Billings Clinic, as well as by contracted providers through InSight Telepsychiatry. Among the specialty services provided through the EMTN, telepsychiatry is the most often utilized. In FY 2016, there were 4,950 total conferences on the EMTN system, with 23% of the consults (834 total) for mental health. Already in FY 2017, there have been 792 consults for mental health, representing 40% of all consults for the year. Despite the high level of utilization for mental health over the EMTN, access to psychiatry through the system is not immediate. On average, there is a two to three month waiting period for an appointment unless a patient is already established with the EMTN.

Avera

Twelve hospitals in the region used time-limited grants to purchase telemedicine equipment for their emergency departments and to cover fees for the Avera eCare Telemedicine Network which allows behavioral health assessments to be provided by clinicians at Avera Health in Sioux Falls, SD. These crisis assessments are available 24/7 in emergency rooms across the region, but there is not a mechanism to bill specifically for the assessments. The annual service fee for Avera in these small hospitals is approximately $60,000 and the grant funding that covered the cost of the service is running out in many of the Eastern Montana facilities this year. If these assessment services are deemed to be an important component of the on-going behavioral health crisis continuum, the hospitals using the service must independently fund the service as grant funding ends, and potentially, develop a means to bill third party payors for the assessments as is being done in other locations.

Avera has also developed capacity for their providers to remotely manage inpatient behavioral health units using telepsychiatry. This service could hold potential to increase psychiatry capacity at the Glendive Medical Center's inpatient behavioral health unit.

InSight Telepsychiatry

Montana Hospital Association (MHA) Ventures promotes the use of InSight Telepsychiatry services, a widely used national telepsychiatry provider organization that uses HIPAA compliant technology to provide scheduled services including assessments, medication management, treatment team meeting support and supervision, as well as on-demand assessments for hospitals within one hour. The InSight Telepsychiatry services are offered 24 hours a day, seven days per week. Scheduled services are billed by the hour, and on-demand services are available for a monthly fee, plus a fee for usage. Adult psychiatry, child psychiatry, and the services of APRNs are available. Nationally, InSight services are being used in hospitals, jails, school, outpatient clinics and other settings. Services can be accessed on computers and mobile devices, and fees include setup, training and testing. As an "endorsed vendor" that is promoted by MHA Ventures, MHA members receive preferred pricing for their services.[43]

Options for mobile crisis

Nationally, there are a number of vendors that provide telehealth technology through using laptops, tablets, smart phones or other portable devices, making it appropriate for use in for mobile crisis response.

SECURE TELEHEALTH AND OMNIJOIN
Secure Telehealth provides software and support for HIPAA compliant video-conferencing for health professionals. A secure telehealth "room" can be purchased for $300 per month. OmniJoin, a free application, can be used to connect with the room, and the connection can occur almost instantaneously. The fee includes free software, on-going training and support, as well as setup assistance and testing. Sessions can be conducted from anywhere an Internet connection is available. There is no limit to the number of devices on which it can be installed or facilities that can use it. Up to 12 participants can join a meeting, which would not likely be needed for crisis response.

Once the parties are logged-in, the room is locked and the session begins. The software includes a "waiting room" where one participant can wait for another.[44] OmniJoin also provides a similar secure videoconferencing service.[45]

ZOOM VIDEO COMMUNICATIONS

Zoom offers a product that could be used for mobile crisis response. A monthly service could be purchased for $199.90 with up to 10 licenses provided, inclusive of software, training, support, setup assistance and testing. Each license is associated with an email address, and ten licenses would allow for 10 separate meetings (crisis events) to occur at one time. Each meeting can host up to 50 participants, which again, would not likely be needed for crisis response, but demonstrates the power of this type of service. A secure waiting room is also provided.[46]

Telephonic behavioral health support services

In addition to mobile crisis response using telehealth technology, there are a number of options for increasing access to telephonic solutions for crisis support. Examples include:

PROTOCALL

One of several national companies that provide telephonic services to behavioral health and other organizations, ProtoCall offers master level clinical professionals who provide telephone support to consumers, as well as crisis intervention and stabilization services. The service can be used after-hours and on weekends, twenty-four hours each day of the week, or as backup to a local crisis line. The service includes documentation of all calls through a secure HIPAA compliant web platform. Use of this type of telephonic service holds potential to free valuable clinical time for providers to work face-to-face with consumers.[47]

HOTLINE BEHAVIORAL HEALTH SUPPORT SERVICES

State and nation-wide hotlines are available to support individuals struggling with suicidal ideation. Providing hotline information to at risk individuals and/or posting information in waiting rooms and in the community, can increase the likelihood that an at-risk individual will reach out for help. The following resources are available at no charge, and these services provide materials that can be printed and posted in order to advertise their availability.

- Montana Suicide Prevention Lifeline: 1-800-273-TALK (1-800-273-8255) This is connected with the National Suicide Prevention Lifeline. Individuals can call or text "MT" to 741 741[48]
- National Suicide Prevention Lifeline: The National Suicide Prevention Lifeline is a national network of over 160 local crisis centers. In addition to the main 1-800-273-8255 lifeline number, there are a variety of population specific resources on the website: Youth, Attempt Survivors, Disaster Survivors, Ayuda En Español, Deaf/Hard of Hearing, LGBTQ+, Loss Survivors, Native Americans and Veterans.
- Veterans Crisis Line: Call 1-800-273-8255 and Press 1 to talk to someone. confidential online chat sessions are at www.VeteransCrisisLine.net/chat or persons can text to 838255 to connect to a VA responder.[50]

Impacts of behavioral health crisis
Strengths and challenges in Eastern Montana

Based on the facilitated stakeholder meeting held in Glendive on March 29, 2017, interviews with local partners, and surveys, a number of strengths and weaknesses of the current system for behavioral health crisis response and jail diversion in the region were identified.

Strengths

INCREASED AWARENESS AND EMPATHY
Across Eastern Montana there is an increased awareness of the problem of behavioral health crisis both among those working in the healthcare settings and in law enforcement. Increasingly, professionals in these fields note that their organizations are seeking to treat individuals in crisis with empathy and compassion, rather than punitively and with fear. One Eastern Montana law enforcement official described his agency's communication style with those in crisis this way, "We are not aggressive, we openly listen and do not talk over them. We make them feel comfortable and not closed in." The shift toward more compassionate, person-centered responses is important as it is considered by SAMHSA to be a core principle in evidence-based crisis response.[51]

REDUCED USE OR DESIRE TO USE JAILS FOR THOSE IN CRISIS
Coupled with a desire for a more compassionate response to those in crisis, is a movement to reduce the use of jails for individuals in behavioral health crisis. Increasingly, law enforcement officials in Eastern Montana report they are partnering with healthcare organizations to support jail diversion solutions so that individuals can be placed in hospitals or other forms of treatment that can better meet their needs.

REGIONAL EMCMHC SERVICES
The EMCMHC is a key safety net provider for behavioral health crisis services in Eastern Montana and their crisis line, hospital assessments and ongoing Community-Based services were often referenced as critical elements of the crisis response system in Eastern Montana. Where these services are readily available and used, Eastern Montana stakeholders feel better supported and able to respond to crises.

COLLABORATION AMONG AGENCIES
Many stakeholders in Eastern Montana note that there are existing collaborations among law enforcement, behavioral health providers and hospitals that are supporting individuals in crisis in the region. As one behavioral health provider put it, "Rural communities tend to work together more due to having fewer available resources. Thinking outside of the box happens more in this area. There are many dedicated providers in multiple arenas in Eastern Montana who care and want to provide the best services possible and help those in need."

COMMUNITY SPECIFIC SOLUTIONS
Though a region-wide, comprehensive behavioral health crisis response system is not in place, communities in the region have taken steps to develop local solutions. As mentioned above, one such solution is the secure crisis room in Frances Mahon Deaconess Hospital in Glasgow. Like any local solution, the room has its challenges. Ellen Guttenburg COO of Frances Mahon Deaconess states, "The safe room is truly a community service….There are people in the hospital that would prefer that we

don't have a safe room. Some people think that it allows the courts to drag their feet and keep people longer than they should be. And staffing the room is an ongoing challenge. The room is good for the community but it is very difficult to manage." Another local solution being implemented in several communities is behavioral health services in county jails. Fallon County Sheriff Trenton Harbaugh coordinates with his local public health nurse to provide services in the jail in Baker. "I've been working with my county health nurse and she is amazing for us. For the first 7 or 8 years, we had zero medical or mental health services at the jail. She has helped us bring in the EMCMHC staff as well and has supported us with funding." These locally grown, collaborative solutions show promise for expanding or

Challenges

Despite the variety of strengths in the current system for behavioral health crisis in Eastern Montana outlined in interviews and surveys, stakeholders identified a number of weaknesses and concerns as well.

COMPLEXITY OF THE PROBLEM

One repeated theme was that the system in Eastern Montana is ill equipped to deal with the complexity of behavioral health crises. Many individuals in crisis present with complex mental health issues combined with co-occurring substance use. At times, crisis events are accompanied by violent, criminal or suicidal behavioral. These individuals may need medication management, housing or employment supports, or SUD treatment. Ross Canen, the Dawson County Sheriff described the problem this way, "With these individuals, it is not only mental illness, it's also chemical dependency issues. It's so many shades of gray." The lack of training, resources and personnel in the region are exacerbated by the reality that this problem is incredibly complex and multifaceted, which means an adaptive, responsive systems needs to be developed that can provide support for the spectrum of crisis events that my present.

building upon a regional system as it is developed.

RE-OPENING OF THE INPATIENT UNIT AT GMC

Many stakeholders saw the GMC Inpatient Behavioral Health Unit as an important resource in the region before it was closed and thus were enthusiastic that the unit is planning to re-open. For individuals in acute behavioral crisis who need longer term care Eastern Montana, this unit was (and if re-opened, will be) the only option for them in this part of the state.

RESOURCE SCARCITY AND COMPLEXITY

As with many issues in rural American, behavioral health crisis is grossly under-funded and -staffed. Thus, all the best efforts of agencies in the area fall short when there are simply not resources available or easily accessible to address the issue holistically. As one law enforcement official put it, "I think we go above and beyond what most other agencies do. My only concern is there is no funding to assist agencies in the eastern part of Montana in dealing with mental health issues." Funding concerns impact agencies' ability to provide training, hire and retain staff, and transport individuals in behavioral health crises. The state of Montana does not fund crisis hotlines, provides limited reimbursement for mobile crisis teams, and there is not ongoing, devoted funding for specific, evidence-based jail diversion programs. This lack of centralized funding has prevented communities from investing in stabilization rooms or other jail diversion facilities. Organizations that provide crisis services must navigate a piecemeal array of funding and reimbursement to support them.

Challenges continued

CONCERNS ABOUT LIABILITY AND STIGMA AMONG PROVIDERS

Many healthcare providers in Eastern Montana are not trained or equipped to work with the SDMI population and worry about their liability and safety working with complex behavioral health patients who may be suicidal or agitated. As Trenton Harbaugh, the sheriff in Fallon County describes, "These folks really should be at the hospital. By law I can't house someone in jail that is under mental distress or that is a suicidal. I have been fighting to get a bed in the hospital. I would pay my law enforcement staff overtime and staff a room in the hospital for these individuals. But everyone is worried about liability. It's a fight that just goes around in circles." There is undoubtedly a stigma around caring for SDMI clients as well as a real and valid concern about healthcare facilities being equipped and staffed to safely care for individuals in crisis. These concerns that must be carefully considered when designing regionalized systems.

TRANSPORTATION

Because facilities in Eastern Montana are not equipped to care for individuals in crisis, scarce resources are often utilized to transport patients long distances to Billings or Warm Springs for higher levels of care. Repeatedly, interviewees and survey recipients talked about transportation challenges in this vast, sparsley populated region. One Eastern Montana law enforcement agent noted, "Giving a patient a shot and transporting them seven hours in a patrol vehicle to Warm Springs is not a good fix. A patient could have a medical issue that the transport officer has no training to monitor or recognize." In addition to concerns about client safety and liability, transportation was regularly cited as a drain on staff

resources. Jane Wolff, a county commissioner in McCone County explained, "We only have four law enforcement people in our county. If someone has to drive someone to Warm Springs, that is an overnight trip and cuts our police force by 25%." Some agencies noted that utilizing scarce staff resources to transport patients in behavioral health crisis actually reduces the safety of the rest of their community. Mary Jo Genhart of the Glendive Ambulance Service put it this way, "We only have six people on our ambulance that take calls. If I take two of my people to transport for an entire day, then that puts the rest of our community at risk. It's a huge deal." Transportation concerns were one of the greatest challenges noted by stakeholders in the research for this report.

USE OF JAILS OR EMERGENCY DEPARTMENTS IN CRISIS DUE TO LACK OF OTHER FACILITIES

Another weakness noted in our research was the lack of facilities for crisis stabilization that aren't high resource solutions like emergency departments, jails or inpatient behavioral health units. One Eastern Montana EMS director put it this way, "Options are very limited here as we don't have anywhere but the hospital to transport these people to."[52] A law enforcement official echoed these sentiments, "We follow procedure in dealing with these type of calls. The breakdown exists between hospital and crisis room availability. We lost the room at Holy Rosary many years ago which places a huge burden and liability on the mental health employees and hospital." With only a single crisis room in the region, the closest crisis stabilization facility is in Billings. Many individuals who participated in our research saw this as a weakness in the current system.

OPTIMIZING USE OF TELEMEDICINE

Several interviewees discussed the fact that, though telemedicine systems are available in the region for crisis assessment, providers struggle to integrate these systems into their crisis response and question if off site crisis assessment is the best course of action. Dale Deide, a physicians assistant working in Ekalaka, noted that he has access to the Avera system in his ED but doesn't use it He explains, "I will admit, I do not want to be talking to someone in Sioux Falls, SD when I am transferring to Billings 90% of the time." Trenton Harbaugh, the sheriff in Fallon County echoed Deide's sentiments, "Avera is not invested in the community--they are not here." Other sites noted that they are working to integrate the use of telemedicine into their behavioral health work and some sites, like the GMC ED, report relying heavily on the Avera system for crisis assessments. Clearly, each site needs more than just access to telemedicine equipment. Providers need ongoing training to determine how to integrate telemedicine into their clinical processes. In addition, the telemedicine equipment currently in use in Eastern Montana usually involves large, place-specific equipment, such as telemedical carts in EDs. More mobile solutions such as internet-based applications using tablets and smart phones are not currently in place in the region.

UNDERUTILIZATION OF EXISTING RESOURCES

Some of the crisis response services that are available in Eastern Montana are underutilized. As stated above, only one surveyed EMS service in Eastern Montana reported using the EMCMHC crisis line along with half of law enforcement agencies. In-hospital crisis assessment services through Avera and EMCMHC are not available in every hospital in the region. In addition, as stated in the policy section of this report, some readily available state funding sources, like the 72-hour crisis stabilization funding, have not been leveraged in Eastern Montana.

STIGMA AND THE CULTURE OF SELF RELIANCE

The culture of Eastern Montana is one of stoic self reliance. One interviewee for this report called it the "Marlboro man" syndrome. Because of this cultural norm, clients may be less likely to seek help for behavioral health concerns and may not present to law enforcement or health professionals until they are in a full blown crisis. The high rates of suicide among men in this region are one indication that many behavioral health concerns are under diagnosed and treated.

LIMITATIONS WITH EXISTING PROVIDERS (EMCMHC AND GMC)

Several interviewees noted that, while the services provided by the EMCMHC and GMC for behavioral health crisis have been helpful, there are limits to the reach and scope of these services. Though EMCMHC provides services across the region, in many counties there are either no services or only part time services available. In the past, EMCMHC provided in-person mobile crisis response, but they have discontinued this service due to staffing shortages. And the behavioral health unit in Glendive, when opened, only has four behavioral health beds that are reserved for those individuals in need of longer term hospital care for behavioral health. The unit is not primarily available for crisis stabilization or detoxification services. Several interviewees noted that, even when the unit was open, they could not always get access to a bed for their most complex, indigent patients. Clearly, the current system is not robust enough to meet the full range of behavioral health crisis needs in Eastern Montana.

Recommendations

Based on results of the stakeholder meeting held March 29, 2017 in Glendive, the epidemiologic, programmatic and survey data collected for this report, interviews with local and national experts and stakeholders, and reviews of policy and funding opportunities, we submit the following recommendations for Eastern Montana to consider to strengthen its capacity to respond effectively to behavioral health crises in the region.

Recommendations for Eastern Montana

FUNDING

Maximize the use of county matching grants. Every year, counties across Montana are eligible to apply for county matching grants for crisis intervention and jail diversion. The region should consider continuing to pool county-level funding to develop regional crisis approaches, with a focus on the following priorities:

- **Behavioral health training** for first responders, law enforcement agencies, primary care providers and other stakeholders. Consider coordinating with the new CIT Program established at the Montana Board of Crime Control and the Eastern Service Area Authority to assure state funding for training is optimized and that trainings are well-coordinated regionally. Training was the top recommendation from Eastern Montana stakeholders at facilitated strategic planning session, supported strongly by agencies across the region.
- **Secure crisis stabilization rooms in hospitals**, similar to the room already in use at Francis Mahon in Glasgow. Regional partners should collaborate to strategically select hospitals willing to develop crisis stabilization rooms in the region, with support from county matching grant funds to retrofit their facilities. Facilities could work with surrounding counties to optimize the use of and provide ongoing funding for the rooms, as access to crisis stabilization will reduce jail costs and allow law enforcement to better handle individuals in behavioral health crisis. Hospitals that agree to develop crisis stabilization rooms could receive enhanced staffing support from EMCMHC. Once the rooms are established, the hospitals should coordinate with DPHHS to optimize the use of 72-hour crisis and other funding to sustain the service and cover costs. These rooms should be created as part of a regional approach to crisis response and jail diversion coordinated with law enforcement, county attorneys, judges and EMCMHC.
- **Telehealth and staffing capacity for virtual 24/7 mobile crisis response** by EMCMHC. Funding could be utilized to support and expand the existing crisis line and to purchase equipment such as tablets and smart phones needed for behavioral health and law enforcement personnel to implement mobile crisis using telehealth. Consider hiring additional crisis staff and subscribing to a secure Internet-based video-conferencing service.
- **Create and sustain peer crisis support services** to assist persons in crisis. Funding could be used for consultation from the successful Montana Peer Network to develop, implement and evaluate peer support and recovery services in the region, similar to the model developed in Gallatin County. This strategy is particularly effective when working with people known to the system and who experience repeat crisis events.

Optimize the use of state funding to sustain crisis services

- At minimum, the EMCMHC, GMC and Frances Mahon Deaconess Hospital should **enroll as providers in the 72-hour crisis stabilization/presumptive eligibility program with DPHHS** and receive training to maximize use of these funds for crisis services.
- GMC should consult with DPHHS to determine if it is feasible and desirable to **provide secure detention bed and/or 14-day crisis stabilization services** as part of a continuum of crisis services offered.

Expand access to SUD treatment.
As described above, Medicaid expansion has created the opportunity for many more people to receive SUD treatment services and passage of HB 95 has created an opportunity for additional providers to become state approved and receive reimbursement. This is an ideal time for EMCMHC to expand its SUD services in the region. While not a direct crisis service, SUD treatment is a crisis prevention strategy.

WORKFORCE AND TRAINING
Increase the number of dually licensed mental health and SUD providers. EMCMHC and other providers could increase capacity for SUD treatment services by increasing the number of dually licensed providers in their organizations. DPHHS is creating a new on-line SUD training. Providers will be able to receive this training, and can then petition the Board of Behavioral Health for approval to provide addiction services.

Maximize the use of mid-level prescribers and telepsychiatry. To address prescriber shortages, the region should continue to maximize the use of mid-level prescribers with oversight by psychiatrists via telehealth.

Maximize the use of the EMCMHC 24/7 crisis line by publicizing it more broadly and encouraging consistent use among providers and responders of all types.

Train place-committed people already in the region. Working with local community colleges and the Montana University System, the region should explore ways to train and educate place-committed people to become behavioral health providers or enhance their licensure using distance learning technologies. A partnership with the psychiatry APRN program at MSU-Bozeman may be of particular interest to healthcare providers in the region.

Incentivize providers to support recruitment.
Maximize the use of Health Professional Shortage Designations for recruitment of providers through the National Health Service Corps and other loan repayment programs.

Train primary care providers to effectively assess and refer behavioral health clients to services.
Primary care providers are an important entry point into the behavioral health system in the region and, as such, could be supported with training on standardized screening tools for alcohol use (SBIRT), suicidal ideation, depression and trauma as well as options for referral. Eastern Montana should identify state and local resources to provide targeted training.

TELEHEALTH
Maximize the use of telehealth technology for crisis response, to address prescriber shortages, for clinical consultation, to increase psychiatry capacity, and to provide backup to on-site providers to reduce burnout and improve retention. Utilize options available through Avera and the EMTN since considerable investment has been made in both systems and relationships are established in the region, while also exploring additional resources.

COLLABORATION

Create an on-going regional collaborative body to continue to develop and refine a regional crisis response and jail diversion system. Strategically engage leaders across the region to spearhead this work, including regional American Indian partners. This group should use the information and recommendations in this report to develop an application for county matching grant funds, beginning in July 1, 2017. This collaboration should involve policy- and other decision-makers to select strategies for implementation region-wide, and/or to pilot test strategies in certain communities. If successful, tested strategies could be disseminated regionwide in future grant years.

Consider national partnership models to catalyze a systematic response framework. Experts interviewed for this report indicated that defined, sustainable partnerships among stakeholders are key to developing and maintaining effective crisis response and jail diversion services. The region should consider national models such as CIT Councils, the NaCO *Stepping Up Program* and the International Chiefs of Police Association's *One Mind Campaign* as frameworks for developing local or regional collaborations among behavioral health, law enforcement, courts, healthcare and other key stakeholders. Having an on-going partnership among these key stakeholders is useful in developing and continuously refining response protocols, and to focus planning on persons known to the system who may experience repeat crisis events.

Formalize a partnership with Billings Clinic or another regional provider for stabilization and care of more complex patients in crisis. As outlined above, many patients in crisis in Eastern Montana are being transferred to Billings Clinic because of its proximity to the region. With Billings Clinic developing a crisis stabilization unit to divert patients from the emergency department and hospital, the region should consider pursuing a closer/more formal relationship to support clients as they are transferred and assure strong linkages back to community-based care once they are discharged.

Explore options to create a shared, secure transport system for individuals in crisis who need care out of the region. If risk and liability issues can be appropriately addressed among jurisdictions, counties could contribute annually to a transportation fund. Off duty law enforcement officers from the region could be employed to transport individuals in crisis. Perhaps a system could be devised whereby counties that "overutilize" the service in a given year (in proportion to their population, based on past MSH utilization and/or other criteria) would make a larger contribution the following year, or conversely, those that "underutilize" it, could receive a discount for the next year.

Develop better connections between crisis care and community-based care post-crisis. A core element of systems designed to prevent and reduce crisis events is improving coordination as patients move among providers, sites of care and levels of care. "Warm hand-offs" involve more than just providing a patient with a referral. It is critically important for a post-crisis patient, that all providers understand their treatment plan and needs.

Recommendations for DPHHS

In the course of our research, we found that many of the effective regional crisis response models were catalyzed by state level decisions to support and systematize crisis response funding and policy. As we explored solutions to the issues of regional crisis services in Eastern Montana, it became clear that many of the potential, evidence-based models that could be implemented in the region would need to be supported at the state level by policy and administrative changes through DPHHS. Below are recommendations for DPHHS that arose from our research.

Require and fund safety net crisis services provided by community-based mental health services.
As outlined in the policy brief portion of this report, there is essentially no required safety net for individuals in mental health crisis who are not currently receiving services through a mental health center in Montana. Consider funding regional community-based mental health centers to provide these services and make them available to any individual in crisis within a service area. Stronger requirements and/or support for crisis response and jail diversion services could offset expensive healthcare and criminal justice expenditures. Consider opportunities available with Medicaid expansion to review and revise the current system to develop a more robust statewide safety net.

Fund local crisis line services or develop a centralized line for the state. As the only required crisis service in the state, 24/7 crisis lines run by community-based mental health centers should be supported by DPHHS through funding and technical assistance. DPHHS could also consider developing a centralized, state-level mental health crisis line that would link to local services.

Streamline and systematize the crisis funding model in the state. DPHHS should assess all crisis funding and consider ways to streamline and optimize the use of these funds, including maximizing allowable Medicaid reimbursement for crisis, so that more providers participate in existing programs. In addition, DPHHS should either provide more technical assistance to providers to better utilize these funds, or consider working to transform the crisis payment system into a more straightforward, systematic model that is accessible to all. Technical assistance and support should be targeted toward lower capacity providers in rural regions who appear to be underutilizing these funds, potentially contributing to health disparities in access and outcomes. Consult with other states that have developed dedicated funding for crisis services or who have streamlined existing models.

Develop a crisis services strategic plan or model for the state. In collaboration with local stakeholders, determine if a systematic regional approach could be implemented statewide to provide crisis response services for all Montanans. Developing and supporting a statewide, systematic model could position Montana to be more competitive for federal SAMHSA funding and support DPHHS goals such as developing Certified Community Behavioral Health Clinics. DPHHS should also explore ways to better support regions and communities in their crisis response planning, as required by Montana law.

Increase the use of bachelor level case managers to support SDMI clients on Medicaid. Case management and care coordination are essential to help people avoid repeat crisis events. Bachelor level case managers are not currently being widely sed to provide these services in Montana, though they are exclusively and successfully used in other states. Especially in rural areas like Eastern Montana, the opportunity to employ and sustain the services of bachelor's trained providers could greatly increase regional capacity to provide essential behavioral health services.

Add a mental health care coordination code to the Medicaid fee schedule. Care coordination is a critical component of addressing crisis events, however, this code is currently only available for reimbursement through 72-hour crisis stabilization/presumptive eligibility funding. Adding the care coordination code to the Medicaid and other fee schedules would improve crisis response and increase effectiveness of coding.

Conclusion

Eastern Montana has many needs related to behavioral health crisis but also many committed, engaged partners who recognize the challenges of addressing this issue in the region and are willing to partner to improve the current system. As we have outlined in this document, the region has many opportunities to optimize reimbursement for crisis services, develop "low tech" stabilization and jail diversion solutions and employ "high tech" solutions like virtual mobile crisis response to link law enforcement and behavioral health. Overwhelmingly, regional partners requested additional training on behavioral health and crisis response, a need that can be met through existing funding and training organizations in the state.

While Eastern Montana is leading the way by developing this regional crisis response and jail diversion strategic plan, there are a number of ways that DPHHS could provide leadership help to support this local effort. Specifically, the Department should consider optimizing and streamlining payment for crisis services, and developing and supporting a statewide model for crisis response and jail diversion to meet the needs of all Montanans.

The recommendations and conclusions from this report represent the professional opinions of the consultants hired for this project. They are not binding upon DPHHS or any organizations in Eastern Montana.

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Appendix A: Coding Overview

Overview

Historically, states were allowed to create and use "Level III" codes (unique code numbering) as part of their billing systems. This changed with the creation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). In August 2000, the Centers for Medicare and Medicaid Services published regulation 45 CFR 162.10002 to implement the HIPAA requirement for a standardized coding system. This established the Health-care Common Procedure Coding System (HCPCS), that since October 2002 is the required coding system for billing.

A review of Montana established fee schedules shows use of HCPCS codes. Fee schedules reviewed include:
- FY 2017 72 Hour Presumptive Eligibility Program for Crisis Stabilization – Individuals 18 years and older Fee Schedule July 1, 2016
    - Care Coordination, Community-based Psychiatric Rehabilitation, and Case Management Services
    - Crisis Intervention and Response
- FY 2017 Medicaid Mental Health Individuals 18 years of age and older Fee Schedule Effective July 1, 2016
    - Practitioner Services
    - Mental Health Center Services
    - Case Management Services
    - Partial Hospitalization
    - Dialectical Behavior Therapy (DBT) Services
- FY 2017 Mental Health Services Plan Individuals 18 years of age and older Fee Schedule Effective July 1, 2016
    - Practitioner Services
    - Mental Health Center Services
    - Case Management Services
- FY 2017 Montana Medicaid – Fee Schedule – Home and Community-Based Services for Adults with Severe Disabling Mental Illness (SDMI)

One of the primary inconsistencies is the Montana Fee Schedule indicating that a code is to be used as a per event code when the code is per 15 minutes increment per federal guidelines. Information provided during interview indicated that these inconsistencies are addressed in CMS approved waiver(s). It will be important to confirm that any critical inconsistencies are specifically included in CMS approved waivers. Without waiver approval thse inconsistencies would create difficulties given the obligation to code services in a HCPCS compliant manner.

Crisis Service Coding

Title 53 (Social Services and Institutions), Chapter 21 (Mentally Ill), Part 12 (Crisis Stabilization Services) defines a crisis as follows: "Crisis" means a serious, unexpected situation resulting from an individual's apparent mental illness in which the individual's symptoms are of sufficient severity, as determined by a mental health practitioner, to require immediate care to avoid: (a) jeopardy to the life or health of the individual; or (b) death or bodily harm to the individual or to others.

In order to respond to the "unexpected" nature of a crisis situation there is a need for specialty crisis codes that do not require the same formal assessment and treatment plan that traditional treatment code use requires. The codes listed by Montana as available for capturing crisis services are:

90832
- Montana Description: Brief individual psychotherapy – 30 minutes
  - 72 Hr. Presumptive Eligibility Program for Crisis Stabilization Fee Schedule – Crisis Intervention and Response
- Medicaid Mental Health – Practitioner Services Fee Schedule and Mental Health Services Plan Fee Schedule – Practitioner Services includes 90832 as a covered code, although they neither indicate nor prohibit it use in relation to crisis coding
- HCPCS Description: Psychotherapy, 30 minutes, with patient. HCPCS refences use when crisis services are less than 30 minutes in total duration

90839
- Montana Description: Psychotherapy for crisis - First 60 minutes
  - Medicaid Mental Health Fee Schedule – Practitioner Services
  - Mental Health Services Plan Fee Schedule – Practitioner Services
- Montana Description: Psychotherapy for crisis – per hour
  - 72 Hr. Presumptive Eligibility Program for Crisis Stabilization – Crisis Intervention and Response Fee Schedule (*documentation support must be submitted)
- HCPCS Description: Psychotherapy for crisis; first 60 minutes

90840
(Note: HCPCS requires 90840 to be used in conjunction with 90839)
- Montana Description: Psychotherapy for crisis (30 min)
  - Medicaid Mental Health Fee Schedule – Practitioner Services
  - Mental Health Services Plan Fee Schedule – Practitioner Services
- HCPCS Description: Each additional 30 minutes

H2011
- Care Coordination -15 min
  - 72 Hr. Presumptive Eligibility Program for Crisis Stabilization Fee Schedule – Care Coordination, Community-based Psychiatric Rehabilitation, and Crisis Management Services
- HCPCS Description: Crisis intervention services, per 15 minutes

S9484
- Crisis Management Mental Health Center Day One, Day Two, and Day Three – per hour
  - 72 Hr. Presumptive Eligibility Program for Crisis Stabilization Fee Schedule – Care Coordination, Community-based Psychiatric Rehabilitation, and Crisis Management Services
- Crisis Management Inpatient Hospital – Day One, Day Two, and Day Three – per hour – Revenue Code 900
  - 72 Hr. Presumptive Eligibility Program for Crisis Stabilization Fee Schedule – Care Coordination, Community-based Psychiatric Rehabilitation, and Crisis Management Services
- HCPCS Description: Crisis intervention mental health services, per hour

S9485
- Crisis intervention facility – per Day
  - Mental Health Services Plan Fee Schedule – Mental Health Center Services
- HCPCS Description: Crisis intervention mental health services, per diem

Community-Based Services Coding

Individuals at risk of crisis events and/or legal system involvement can benefit from Community-Based services that include a broad array of supports and skill development. Specific service configurations should be tailored to the needs of the individual.

Community-based psychiatric rehabilitation and support services are outlined in ARM 37.88.901 (3) and outline an array of support services designed to "assist individuals in developing the skills and behaviors necessary for recovery." These services can decrease the probability of a future crisis event and/or assist the individual in transitioning back into the community following a hospitalization or jail event.

In ARM 37.88.901 (3), "Community-based psychiatric rehabilitation and support" means services provided in home, school, workplace, and community settings for adults with severe disabling mental illness. Services are provided by trained mental health personnel under the direction of and according to individualized treatment plans. The services may be provided outside of normal clinical or mental health program settings and are designed to assist individuals to develop skills and behaviors necessary for recovery. Community-based psychiatric rehabilitation and support services are provided on a face-to-face basis with the individuals, family members, teachers, employers or other key individuals in the individual's life when such contacts are clearly necessary to meet goals established in the individualized strength-based treatment plan.

Community-Based services continued

(a) Community-based psychiatric rehabilitation and support includes, but is not limited to, the following services:

   (i) evaluation and assessment of symptomatic, behavioral, social and environmental barriers to independent living and community integration;

   (ii) assisting the individual to develop communication skills, self-management of psychiatric symptoms, and the social networks necessary to minimize social isolation and increase opportunities for a socially integrated life;

   (iii) assisting the individual to develop daily living skills and behaviors necessary for maintenance of a home, family relationships and responsibilities, an appropriate education, employment or vocational situation, and productive leisure and social activities; and

   (iv) *immediate intervention in a crisis situation and referral to necessary and appropriate care and treatment.*

H2019 is the code assigned by Montana for community-based psychiatric rehabilitation and support service.

H2019 descriptions include:

- Community-based psychiatric rehabilitation & support – individual -per 15 minutes
    - Medicaid Mental Health Fee Schedule – Mental Health Center Services
    - Mental Health Services Plan Fee Schedule – Mental Health Center Services
    - 72 Hr. Presumptive Eligibility Program for Crisis Stabilization Fee Schedule – Care Coordination, Community-based Psychiatric Rehabilitation, and Crisis Management Services
- Community-based psychiatric rehabilitation & support – group -per 15 minutes
    - Medicaid Mental Health Fee Schedule – Mental Health Center Services
    - Mental Health Services Plan Fee Schedule – Mental Health Center Services
- HCPCS Description: Therapeutic behavioral services, per 15 minutes

Targeted Case Management is another service array that can have a positive impact on an individual's ability to maintain within the community and avoid crisis events. Descriptions include:

ARM 37.86.3301 (1) "Case management" means the process of planning and coordinating care and services to meet individual needs of a client and to assist the client in obtaining necessary medical, social, nutritional, educational, and other services. Case management includes assessment, case plan development, monitoring, and service coordination. Case management provides coordination among agencies and providers in the planning and delivery of services.

ARM 37.86.3305 (1) Case management services assure healthy outcomes by assisting recipients to access needed services and by coordinating between all agencies and providers responsible for service delivery. A case management plan sets goals for meeting a client's needs and where appropriate the needs of the client's caregivers and identifies the means for implementing those goals with emphasis on the self-sufficiency of the client and caregivers in obtaining services.

ARM 37.86.3306 (1) Persons who are Medicaid recipients and are from the following groups are eligible for case management services:…(b) adults with severe disabling mental illness;

ARM 37.86.3501 (1) "Case management" services means services furnished to assist Medicaid and mental health services plan eligible individuals who reside in a community setting, or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.

ARM 37.86.3505 (1) Case management services for adults with severe and disabling mental illness include:
 (a) comprehensive assessment and reassessment at least once every 90 days of an eligible individual to determine service needs, including activities that focus on needs identification for any medical, educational, social, or other services. These assessment activities include the following:
  (i) taking client history;
  (ii) identifying the needs of the individual, and completing related documentation; and
  (iii) gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual and to avert crisis.
 (b) development (and periodic revision) of a specific care plan based on the information collected through the assessment that:
  (i) specifies goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
  (ii) includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals;
  (iii) identifies a course of action to respond to the assessed needs of the eligible individual and to avert crisis.
 (c) referral and related activities (such as making referrals and scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that link the individual with medical, social, and educational providers or other programs and services that address identified needs and achieve goals specified in the care plan; and
 (d) monitoring and follow-up activities, including activities and contacts to ensure that the care plan is effectively implemented and addresses the needs of the eligible individual. Activity may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and at least once every 90 days, to help determine whether the following conditions are met:
  (i) services are being furnished in accordance with the individual's care plan;

Community-Based services continued

    (ii)   services in the care plan are adequate to meet the needs of the individual; and

    (iii)   there are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

T1016 is the code assigned by Montana for Targeted Case Management.

T1016 descriptions include:

- Targeted Case Management – Adult, Individual - per 15
  - Medicaid Mental Health Fee Schedule – Case Management Services
  - Mental Health Services Plan Fee Schedule – Case Management Services
- HCPCS Description: Case management, each 15 minutes

The Home and Community-Based Services for Adults with Severe Disabling Mental Illness (SDMI) Fee Schedule designates H0032 as Case Management – per Day, however the HCPCS description is Mental Health Service Plan Development by non-physician. Unless covered by a CMS waiver, this is problematic as the two descriptions are inconsistent in their scope of activity.

Illness Management and Recovery (IMR) is an evidence based practice curriculum that includes a strong emphasis on helping individuals set and implement their personal recovery goals. ARM 37.88.901 (7) "Illness management and recovery" means a program to help individuals who have experienced psychiatric symptoms to develop personalized strategies for managing their mental illness and moving toward recovery. Such a program can be provided in an individual or group format.

H2015 is the code assigned by Montana for IMR – individual services.
- H2015 descriptions include: Illness Management and Recovery – Individual - per 15 min
  - Medicaid Mental Health Fee Schedule – Mental Health Center Services
  - Mental Health Services Plan Fee Schedule – Mental Health Center Services
- HCPCS description: Comprehensive community support services, per 15 minutes

H2017 is the code assigned by Montana for IMR – group services
- H2017 descriptions include:Illness Management and Recovery – Group - per 15 min
  - Medicaid Mental Health Fee Schedule – Mental Health Center Services
  - Mental Health Services Plan Fee Schedule – Mental Health Center Services
- HCPCS Description: Psychosocial rehabilitation services, per 15 minutes

The following coding tables take the most recent version of eligible codes by the various Fee Schedules and com-

Code tables

pare titles and unit application with CPT/HCPC established titles and units. These tables are meant as a general reference guide. For official CPT/HCPC information refer to Federally authorized sources.

FY 2017 72 Hour Presumptive Eligibility Program for Crisis Stabilization Fee Schedule

Practitioner Services – Psychiatric Procedures			
Practitioners bill using CPT codes and are reimbursed according to the Department's RBRVS system. http://medicaidprovider.mt.gov/proposedfs			
Practitioner Services – Evaluation & Management			
E&M CPT codes may be provided and billed by physicians, physician assistants, and nurse practitioners and are reimbursed according to the Department's RBRVS system.			
Care Coordination, Community-based Psychiatric Rehabilitation, and Crisis Management Services			
* Note for enrolled hospitals and enrolled facilities including licensed mental health centers - Crisis management services are paid on an all-inclusive bundled hourly rate. Payment authorization and limits apply.			
Code	**Montana Title**	**Federal CPT/HCPC Title**	**Comments**
H2011	Care Coordination (per 15) (Limits: 12 units per day)	Crisis intervention services, per 15 minutes	
H2019	Community-based psychiatric rehabilitation & support – individual (per 15) (Limits: None)	Therapeutic behavioral services, per 15 minutes	Montana title is rather close to H0036: Community psychiatric supportive treatment, face to face, per 15 minutes
S9484	Crisis Management Mental Health Center (per hour – Day One, Two, and Three) (Limits: 24 per day)	Crisis intervention mental health services, per hour	
S9484 – Revenue Code 900	Crisis Management Inpatient Hospital (per hour – Day One, Two, and Three) (Limits: 24 per day)	Crisis intervention mental health services, per hour	
Crisis Intervention and Response			
90832	Brief individual psychotherapy (30 min)	Psychotherapy, 30 minutes, with patient	For use when psychotherapy for crisis is less than 30 minutes total duration.
90839	Psychotherapy for crisis (per hour) (*requires document submission)	Psychotherapy for crisis, first 60 minutes	90839 is only used for the first 30 – 74 minutes. It is not designated for ongoing "hourly".

Acute Inpatient Services			
Acute care hospital services, to Medicaid members, are reimbursed under the Montana Medicaid program's Diagnosis Related Group (DRG) reimbursement system. Requires prior authorization			
Code	**Montana Description**	**Federal HCPCS Title**	**Additional Details**
Practitioners Services			
90791	Psychiatric diagnostic evaluation (no medical) (per session)	Psychiatric diagnostic evaluation	
90792	Psychiatric diagnostic evaluation (medical) (per session)	Psychiatric diagnostic evaluation with medical services	
90832	Brief Individual psychotherapy (16-37 minutes)	Psychotherapy, 30 minutes with patient	
90833	Psychotherapy with E&M (16-37 minutes)	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(List separately in addition to the code for primary procedure)	
90834	Individual psychotherapy (38-52 minutes)	Psychotherapy, 45 minutes with patient	
90836	Psychotherapy with E&M (38-52 minutes)	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service(List separately in addition to the code for primary procedure)	
90837	Individual psychotherapy (greater than 53 minutes)	Psychotherapy, 60 minutes with patient	
90838	Individual Psychotherapy with E&M (greater than 53 minutes)	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service(List separately in addition to the code for primary procedure)	
90839	Psychotherapy for crisis (1st 60 min)	Psychotherapy for crisis; first 60 minutes	
90840	Psychotherapy for crisis (30 minutes)	Each additional 30 minutes	*Must be paired with 90839

90785	Interactive complexity (per session)	Interactive complexity	*Add on code
90846	Family psychotherapy without member (per session)	Family psychotherapy (without the patient present) 50 minutes	
90847	Family psychotherapy with patient (per session)	Family psychotherapy (conjoint psychotherapy) (with patient present) 50 minutes	
90853	Group psychotherapy (other than multi-family) (per session)	Group psychotherapy (other than of a multiple-family group)	
96101 AH	Psychological testing including psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities (per hour)	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time both face to face time administering rest to the patient and time interpreting these test results and preparing the report	
96102 AH	Psychological testing by technician (per hour)	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI and WAS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face to face	
96103 AH	Psychological testing administered by computer (per test battery)	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI), administered by a computer, with qualified health care professional interpretation and report	

Mental Health Center Services			
S5102	MH Group Home – Adult (per day)	Day care services, adult; per diem	Match concern: nature of day care services versus the 24/7 of being in a group home
S5102	MH Group Home Therapeutic Leave (per day) (14 days/year limit)	Day care services, adult; per diem	*same comment as above
S5140	Adult Foster Care (per day)	Foster care, adult; per diem	
S5140	Adult Foster Care (per day) (14 days/year limit)	Foster care, adult; per diem	
H2012	Day Treatment – Adult Half Day (per hour) (3 hours/day limit)	Behavioral health day treatment, per hour	
H2019	Community-based psychiatric rehabilitation & support – individual (per 15 min)	Therapeutic behavioral services, per 15 minutes	Montana title is rather close to H0036: Community psychiatric supportive treatment, face to face, per 15 minutes
H2019	Community-based psychiatric rehabilitation & support – group (per 15 min)	Therapeutic behavioral services, per 15 minutes	Montana title is rather close to H0036: Community psychiatric supportive treatment, face to face, per 15 minutes
H2015	Illness Management and Recovery – Individual (per 15 min)	Comprehensive community support services, per 15 minutes	Same code is used with two different titles across fee schedules: Home and Community Based Services – SDMI fee schedule uses this code for Consultative Clinical and Therapeutic Services
H2017	Illness Management and Recovery – Group (per 15 min)	Psychosocial rehabilitation services, per 15 minutes	
S9485	Crisis Intervention Facility (per day)	Crisis Intervention mental health services, per diem	
H0040	Program of Assertive Community Treatment (PACT) (per day)	Assertive community treatment program, per diem	
S5102	Intensive Community Based Rehabilitation (per day)	Day care services, adult; per diem	Activity match concern

Case Management Services *Licensed MHC must have case management endorsement			
T1016	Targeted Case Management – Adult, Individual (per 15)	Case management, each 15 minutes	
Partial Hospitalization			
H0035	Acute Partial Hospitalization Full day (28-day recommended limit – may be extended if medically necessary)	Mental health partial hospitalization, treatment, less than 24 hours	*need to be mindful when applying "full day" criteria due to the requirement that code be used for events that are less than 24 hours
H0035	Acute Partial Hospitalization Half day (28-day recommended limit – may be extended if medically necessary)	Mental health partial hospitalization, treatment, less than 24 hours	
Dialectical Behavior Therapy (DBT) Services *must be trained and certified in DBT			
H0046	Intensive Outpatient Services (40-50 min)	Mental Health Services, not otherwise specified	Not a strong match between titles
H2014	Dialectical Behavior Therapy – Skill Development – Individual (per 15)	Skills Training and Development, per 15 minutes	
H2014	Dialectical Behavior Therapy – Skill Development – Group (per 15)	Skills Training and Development, per 15 minutes	

Code	Montana Description	Federal HCPCS Title	Additional Details
Practitioners Services			
90791	Psychiatric diagnostic evaluation (no medical) (per session)	Psychiatric diagnostic evaluation	
90832	Brief Individual psychotherapy (16-37 minutes)	Psychotherapy, 30 minutes with patient	
90834	Individual psychotherapy (38-52 minutes)	Psychotherapy, 45 minutes with patient	
90837	Individual psychotherapy (greater than 53 minutes)	Psychotherapy, 60 minutes with patient	
90839	Psychotherapy for crisis (1st 60 min)	Psychotherapy for crisis; first 60 minutes	
90840	Psychotherapy for crisis (30 minutes)	Each additional 30 minutes	*Must be paired with 90839
90785	Interactive complexity (per session)	Interactive complexity	*Add on code
90846	Family psychotherapy without member (per session)	Family psychotherapy (without the patient present) 50 minutes	
90847	Family psychotherapy with patient (per session)	Family psychotherapy (conjoint psychotherapy) (with patient present) 50 minutes	
90853	Group psychotherapy (other than multi-family) (per session)	Group psychotherapy (other than of a multiple-family group)	
96101 AH	Psychological testing including psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities (per hour)	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time both face to face time administering rest to the patient and time interpreting these test results and preparing the report	
96102 AH	Psychological testing by technician (per hour)	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI and WAS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face to face	

96103 AH	Psychological testing administered by computer (per test battery)	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI), administered by a computer, with qualified health care professional interpretation and report	
Mental Health Center Services			
S5102	MH Group Home – Adult (per day)	Day care services, adult; per diem	Match concern: nature of day care services versus a group home
S5102	MH Group Home Therapeutic Leave (per day) (14 days/year limit)	Day care services, adult; per diem	*same comment as above
S5140	Adult Foster Care (per day)	Foster care, adult; per diem	
S5140	Adult Foster Care (per day) (14 days/year limit)	Foster care, adult; per diem	
H2012	Day Treatment – Adult Half Day (per hour) (3 hours/day limit)	Behavioral health day treatment, per hour	
H2019	Community-based psychiatric rehabilitation & support – individual (per 15 min)	Therapeutic behavioral services, per 15 minutes	Montana title is rather close to H0036: Community psychiatric supportive treatment, face to face, per 15 minutes
H2019	Community-based psychiatric rehabilitation & support – group (per 15 min)	Therapeutic behavioral services, per 15 minutes	Montana title is rather close to H0036: Community psychiatric supportive treatment, face to face, per 15 minutes
H2015	Illness Management and Recovery – Individual (per 15 min)	Comprehensive community support services, per 15 minutes	Same code is used with two different titles across fee schedules: Home and Community Based Services – SDMI fee schedule uses this code for Consultative Clinical and Therapeutic Services

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FY 2017 MHSP (Adult) Fee Schedule (Effective July 2016)-continued

H2017	Illness Management and Recovery – Group (per 15 min)	Psychosocial rehabilitation services, per 15 minutes	
S9485	Crisis Intervention Facility (per day)	Crisis Intervention mental health services, per diem	
H0040	Program of Assertive Community Treatment (PACT) (per day)	Assertive community treatment program, per diem	
S5102	Intensive Community Based Rehabilitation (per day)	Day care services, adult; per diem	Activity match concern
Case Management Services *Licensed MHC must have case management endorsement			
T1016	Targeted Case Management – Adult, Individual (per 15)	Case management, each 15 minutes	

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*All home and Community-Based services procedure codes must be followed by a UA modifier

*With the exception of H0032, all services require pre-authorization

Code	Montana Title	Federal CPT/HCPC Title	Additional Details
H0004	Substance Use Related Disorders Counseling – Individual (per 15)	Behavioral Health Counseling and Therapy, per 15 minutes	
H0005	Substance Use Related Disorders – Group (per visit)	Alcohol and/or Drug Services; Group Counseling by a Clinician	
H0032	Case Management (per day)	Mental Health Service Plan Development by non-physician	Activity match concern
H0045	Respite Care – Assisted Living (per diem)		
H0045	Respite Care – Nursing Facility (per diem)		

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H2015	Consultative Clinical and Therapeutic Services (per service)	Comprehensive community support services, per 15 minutes	Unit issue. H2015 is not a per service code. Also, same code two different titles across fee schedules: Mental Health Center Services fee schedule titles H2015 as Illness Management and Recovery – Individual, per 15
H2021	Peer Support (per 15)	Community Based Wraparound Services, per 15 minutes	Code match concern: H0038 would be a more specific code as it is "Self-help/peer services, per 15 minutes" code
H2032	Health & Wellness (per session)	Activity Therapy, per 15 minutes	Unit issue. H2032 is not a per session code
H2032	Adaptive Recreational Therapy (per session)	Activity Therapy, per 15 minutes	Unit issue. H2032 is not a per session code
H2032	Exercise Class (per class)	Activity Therapy, per 15 minutes	Unit issue. H2032 is not a per class code
H2032	Health Club Membership (Monthly)	Activity Therapy, per 15 minutes	Unit issue. H2032 is not a per month code
H2032	Hippotherapy (per session) *assume typo issue	Activity Therapy, per 15 minutes	Unit issue. H2032 is not a per session code
H2032	Wellness Classes (per session)	Activity Therapy, per 15 minutes	Unit issue. H2032 is not a per session code
S0215	Transportation – Miles (per mile)	Nonemergency transportation; mileage, per mile	
S5100	Adult Day Care (per 15 min)	Day care services, adult; per 15 minutes	
S5116	Overnight Supports (per diem)	Home care training, nonfamily; per session	Match issue: S5116 is about training a non-family member in home care. This is not consistent with providing overnight support activities
S5125	Specially Trained Attendants (per 15)	Attendant care services; per 15 minutes	
S5130	Homemaker (per 15)	Homemaker service, NOS, per 15 minutes	

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S5131	Homemaker Chores (per diem)	Homemaker service, NOS, per diem	
S5135	Companion Services (per 15)	Companion care, adult (e.g. IADL/ADL); per 15 minutes	
S5160	Personal Emergency Response System – installation & testing (per item)	Emergency response system; installation and testing	
S5161	Personal Emergency Response – Rental (per month)	Emergency response system; service fee, per month (excludes installation and testing)	
S5162	Personal Emergency Response System – Purchase (per item)	Emergency response system; purchase only	
S5165	Environmental Accessibilty Adaptations – Home Modifications (per service)	Home modification; per service	
S5170	Nutrition (Meals) (per meal)	Home delivered meals, including preparation; per meal	
T1001	Nursing Assessment/Evaluation/Supervision (per 15 min)	Nursing assessment/evaluation	Unit and Title match issue: T1001 is not a per 15-minute code. While it does include assessment and evaluation, it does not indicate inclusion of supervision
T1002	Private Duty Nursing – RN (per 15 minutes)	RN services, up to 15 minutes	
T1003	Private Duty Nursing – LPN (per 15 minutes)	LPN/LVN services, up to 15 minutes	
T1005	Respite Care (per 15)	Respite care services, up to 15 minutes	
T2019	Supported Employment (per 15)	Habilitation, supported employment, waiver; per 15 minutes	
T2021	Life Coach (per 15)	Day habilitation, waiver; per 15 minutes	Match Concern
T2025	Pain and Symptom Management (per session)	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.

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Home and Community-Based Services for Adults
with Severe Disabling Mental Illness (SDMI)-continued

T2025	Acupuncture (per session)	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.
T2025	Chiropractic (per session	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.
T2025	CranioSacral Therapy (per session)	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.
T2025	Hyperbaric Oxygen Therapy (per session)	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.
T2025	Massage Therapy (per session)	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.
T2025	Specialized Nursing Services (per session)	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.
T2025	Pain Mitigation Counseling/Coaching (per treatment)	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.
T2025	Reflexology (per session)	Waiver services; not otherwise specified (NOS)	Use of NOS codes is generally for when there is not a more specific code available.
T2028	Specialized Medical Supplies (per item)	Specialized supply, not otherwise specified, waiver	
T2029	Specialized Medical Equipment (per item)	Specialized medical equipment, not otherwise specified, waiver	
T2031	Residential Habilitation – Assisted Living Facilities and Adult Foster Homes (per day)	Assisted living; waiver, per diem	
T2038	Community Transition Services (per service)	Community transition, waiver, per service	

Appendix B: Montana Code Annotated (MCA) and Adminsitrative Rules of Montana (ARM) reviewed

MCA and ARM Crosswalk			
MCA	**Description**	**ARM**	**Description**
2-9-211	Political Subdivision Insurance		
53-6-101	Montana Medicaid Program – authorization of services		
53-21-102	Treatment of the Seriously Mentally Ill	37.91.102	Certification of Mental Health Persons – General Requirements: Exemptions
		37.106.1704	Behavioral Health Inpatient Facilities: Definitions
53-21-106	Certification of Professional Persons	37.91.101	Professional Person Certification
		37.91.102	Exemptions
		37.91.106	Definitions
		37.91.201	Application Process
		37.91.205	Expiration and Renewal of Certification
		37.91.210	Revocation of certification
		37.91.220	Continuation of Certification
		37.91.401	Requirements for Full Mental Health Certification
		37.91.402	Privileges of Full Mental Health Certification
		37.91.406	Requirements for Facility Mental Health Certification
		37.91.407	Privileges of Facility Mental Health Certification
		37.91.601	Appeal Process
		37.91.1713	Personnel Records
53-21-120	Detention to be in Least Restrictive Environment – Preference for Mental Health Facility – Court Relief – Prehearing Detention of Mentally Ill Person Prohibited		
53-21-124	Detention of Respondent Pending Hearing or Trial – Jail Prohibited		

ARM	Description	ARM	Description
53-21-127	Post-trial Disposition		
53-21-129	Emergency Situation – Petition - Detention	37.106.1731	Transfer/Discharge to Another Facility
53-21-132	Cost of Examination and Commitment		
53-21-193	Commitment to Behavioral Health Inpatient Facilities – Preference – Voluntary Treatment		
53-21-1001	Service Area Authorities: Definitions		
53-21-1002	Service Area Authorities: Duties of Department		
53-21-1006	Service Area Authorities: Leadership Committees – Boards - Plans		
53-21-1007	Service Area Authorities: Mental Health Services Contracts		
53-21-1010	Service Area Authorities: County Commissioners – Community Mental Health Centers – Licensed Mental Health Centers		
53-21-1011	Service Area Authorities: Continuation of Services		
53-21-1013	Service Area Authorities: Purpose		
53-21-1101	Suicide Prevention Officer: Duties		
53-21-1102	Suicide Reduction Plan		
53-21-1103	Suicide Hotline		
53-21-1201	Diversion of Certain Persons Suffering from Mental Disorders from Detention Center		
53-21-1202	Crisis Intervention Programs - Rulemaking Authority	37.89.1025	Contracts for Payment of Short-Term Inpatient Treatment

ARM	Description	ARM	Description
53-21-1203	State Matching Fund Grants for County Crisis Intervention, Jail Diversion, Pre-commitment, and Short-Term Inpatient Treatment Costs	37.89.1001	Grants to Counties, Goals and Outcomes
		37.89.1003	Grants to Counties, Participants
		37.89.1005	Grants to Counties, Determining Grant Amounts
		37.89.1007	Grants to Counties, Pro Rata Distribution
		37.89.1009	Grants to Counties, Strategic Plan Requirements
53-21-1204	Department to Contract for Detention Beds	37.89.1021	Jail Diversion and Crisis Intervention, Contracts for Psychiatric Treatment Beds
53-21-1205	Short-Term Inpatient Treatment - Process - Placement - Length - Conditions for Proceeding with Commitment Hearing	37.89.1025	Contracts for Payment of Short-Term Inpatient Treatment
53-21-1206	Treatment and Discharge Plan - Safety - Sights		
53-21-1401	Definitions		
53-21-1402	Purpose - Limitations		
53-21-1403	Crisis Stabilization Services - Requirements		
53-21-1404	Claims and Reimbursement - Exceptions		
53-21-1405	Rulemaking Authority		
		53-21-1401 through 53-21-1405 Associated ARM	
		37.89.501	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Definition
		37.89.503	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Limitations
		37.89.505	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Crisis Management Services
		37.89.507	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Crisis Stabilization

MCA	Description	ARM	Description
		37.89.509	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Claims and Reimbursement
		37.89.521	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Reimbursable Services
		37.89.523	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Reimbursement for Services
		37.89.525	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Reimbursement for Exclusions
		37.89.531	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Where Services may be Provided
		37.89.541	72-Hour Presumptive Eligibility for Adult Crisis Stabilization Services: Confidentiality Requirements

Additional ARMs reviewed

ARM	Description
37-3-102	Medicine: Definitions
33-22-138	Disability Insurance – General Provisions: Coverage for Telemedicine Services
37.85.406	Billing, Reimbursement, Claims Processing, and Payment
37.86.601	Therapy Services: Definitions
37.86.605	Therapy Services: Provider Requirements
37.86.610	Therapies: Reimbursement
37.86.3301	Case Management Services: General Definitions
37.86.3305	Case Management Services: General Provisions
37.86.3306	Case Management Services: General Eligibility
37.86.3501	Case Management Services for Adults with Severe Disabling Mental Illness: Definitions
37.86.3502	Case Management Services for Adults with Severe Disabling Mental Illness: Eligibility
37.86.3503	Case Management Services for Adults with Severe Disabling Mental Illness: Severe Disabling Mental Illness
37.86.3505	Case Management Services for Adults with Severe Disabling Mental Illness: Service Coverage
37.86.3506	Case Management Services for Adults with Severe Disabling Mental Illness: Service Requirements
37.86.3507	Case Management Services for Adults with Severe Disabling Mental Illness: Provider Requirements
37.86.3515	Case Management Services for Adults with Severe Disabling Mental Illness: Reimbursement
37.86.4001	Targeted Case Management Services for Substance Use Disorders: Definitions
37.86.4002	Targeted Case Management Services for Substance Use Disorders: Eligibility
37.86.4005	Targeted Case Management Services for Substance Use Disorders: Service Coverage
37.86.4006	Targeted Case Management Services for Substance Use Disorders: Service Requirement
37.86.4007	Targeted Case Management Services for Substance Use Disorders: Provider Requirements

Additional ARMs reviewed

ARM	Description
37.86.4010	Targeted Case Management Services for Substance Use Disorders: Reimbursement
37.88.901	Mental Health Center Services for Adults: Definitions
37.88.903	Mental Health Center Services for Adults: Defined
37.88.905	Mental Health Center Services for Adults: Requirements
37.88.906	Mental Health Center Services for Adults: Covered Services
37.88.907	Mental Health Center Services for Adults: Reimbursement
37.88.908	Mental Health Center Services for Adults: Program of Assertive Community Treatment (PACT)
37.88.909	Mental Health Center Services for Adults: Intensive Community Based Rehabilitation Facility
37.89.103	Mental Health Services Plan: Definition
37.89.106	Mental Health Services Plan: Member Eligibility
37.89.112	Mental Health Services Plan: Outpatient Drugs for Beneficiaries Eligible for Medicare
37.89.119	Mental Health Services Plan: Premium Payments and Member Copays
37.89.125	Mental Health Services Plan: Provider Reimbursement
37.106.1906	Mental Health Center: Services and Licensure
37.106.1945	Mental Health Center: Crisis Telephone Services
37.106.1946	Mental Health Center: Inpatient Crisis Stabilization Program