Children, Families, Health, and Human Services Interim Committee

67th Montana Legislature

TO: Children, Families, Health, and Human Services Interim Committee

FROM: Sue O'Connell, Legislative Research Analyst
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DATE: January 10, 2022

RE: Study-Related Questions from November Meeting

This memorandum responds to committee requests made at or after the committee's November meeting, seeking additional information related to the SJR 14 study of the adult mental health system, the HJR 35 study of the children's mental health system, and the HJR 39 study of the commitment of individuals with dementia.

1. Assisted Living Administrative Rule

Question Raised: Please provide more information about the administrative rule that allows assisted living facilities to discharge residents.

Followup Information: The criteria for involuntary discharge from an assisted living facility are established in 37.106.2824, Administrative Rules of Montana (ARM). A facility may require a resident to leave for several different reasons, including when the person's care needs exceed the level of service provided at the facility, the person's actions affect the health and safety of others, the person requires psychiatric treatment, or the person's cognitive abilities have declined to the point that the facility can no longer serve the person. Typically, the facility must provide 30 days' notice before the person is discharged, except in situations involving a medical emergency or an immediate danger to the resident or others.

2. Community Behavioral Health Aides[1,2]

Question Raised: What has happened with certification of community behavioral health aides since passage of HB 599 in 2019? How many have been certified, where are they practicing, how many people have been served, and how many Medicaid claims for services have been submitted?

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[1] Discussion with Lesa Evers, Tribal Relations Manager, Department of Public Health and Human Services. Dec. 3, 2021.

[2] "Montana Health and Behavioral Health Paraprofessionals Workforce." *Montana Healthcare Workplace Advisory Committee* and *Montana Office of Rural Health/Area Health Education Center*. 2020.

Followup Information: HB 599 created the framework for Montana to participate in a community health aide program authorized under the federal Indian Health Care Improvement Act. The federal act allows community health aides to practice in certain tribal facilities without receiving licensure through the state. Instead, the person must be certified by either a certification board established in accordance with federal law or by a tribe that has adopted certification standards that meet or exceed the requirements of a federal certification board. HB 599 also made the services of certified community health aides a reimbursable Medicaid service.

Work continues on establishing a certification board to implement the program in Montana. At this point, the opportunity for certification of behavioral health aides does not yet exist. The Department of Public Health and Human Services is waiting until the certification standards are in place before it submits an amendment to the state Medicaid plan to allow reimbursement for the services.

Three tribal colleges have established behavioral health aide certificate programs – Aaniih Nakoda College in Harlem, Blackfeet Community College in Browning, and Chief Dull Knife College in Lame Deer.

3. CSCT Waiting Lists[3]

Question Raised: Are there waiting lists for CSCT services?

Followup Information: DPHHS has heard anecdotally that some schools have waiting lists for services. However, the agency does not track that information and does not know the extent to which waiting lists may exist.

4. Dementia Training

Question Raised: Please research statutes and administrative rules related to dementia training in assisted living facilities.

Followup Information: There are not any statutes or rules that specifically reference dementia training in assisted living facilities; however, there are specific ARM requirements regarding training in cognitive impairments in Category C assisted living facilities. In addition, there are currently proposed Category D ARMs (MAR Notice No. 37-909) that, if adopted, would require training in mental health and the management of resident behaviors.

Sections 50-5-225 through 50-5-228, MCA, govern the licensure of assisted living facilities. Section 50-5-226 requires DPHHS to adopt rules for staffing Category A through D assisted living facilities, including for Category C and D facilities "the provision of specialty care to residents with cognitive impairments, and additional qualifications of and training for the administrator and direct-care staff. The standards for a category D assisted living facility must also include specific safety and restraint training." (50-5-226(8)(f).)

Training requirements are contained in the following administrative rules:

- ARM 37.106.2816: new employees must receive orientation and training in relevant areas, direct care staff must receive training to perform the services required in each resident care plan, and direct care staff must have knowledge of residents' needs and events about which staff should notify the administrator.

[3] Discussion with Meghan Peel, DPHHS Children's Mental Health Bureau Chief. Jan. 3, 2002.

- ARM 37.106.2876: direct care staff at Category B facilities must show documentation of in-house training related to the care and services they are to provide under direct supervision of a registered nurse.
- ARM 37.106.2891: administrators of Category C facilities must receive 8 of their required 16 hours of annual continuing education in caring for persons with severe cognitive impairments.
- ARM 37.106.2892: additional training for direct care staff in Category C facilities must include the facility's philosophy and approaches to providing care and supervision for persons with cognitive impairments and techniques for minimizing challenging behaviors.

Finally, MAR Notice No. 37-909 proposes new rules for Category D assisted living facilities, including requirements that administrators receive 8 of their 16 required continuing education hours in the field of mental health, that staff be trained de-escalation techniques and methods for managing resident behaviors, and that staff complete 6 hours of annual training related to mental health.

5. Mobile Crisis Services[4,5,6]

Questions Raised: Several questions were raised after the November presentation regarding mobile crisis teams. The questions and answers are listed below.

Q: What are the payment sources for services provided by mobile crisis teams?
A: Medicaid is not yet an approved funding source for mobile crisis services. The mobile crisis teams currently operating in Montana are funded with state grants and may bill private insurance or other third-party payers to help cover costs. The state is preparing to make mobile crisis services a Medicaid-reimbursed service effective July 1, 2022. The crisis services would have to be provided by a team consisting of a mental health professional, a paraprofessional (which could include a certified peer support specialist), and a care manager. DPHHS is still determining which types of entities will be able to become a crisis provider for the purposes of Medicaid reimbursement.

Q: What percent of crisis calls answered by mobile crisis teams involve a publicly insured person and what percent also relate to substance abuse?
A: DPHHS has not yet collected this information from the mobile crisis teams. The agency is working with the teams on the reporting requirements and expects to have the data later this year.

Q: What happens when a crisis call involves children? Is there a relationship with CPS?
A: Most crisis teams are still responding to calls in conjunction with a law enforcement partner. If a call involves a person with a child, the typical protocol would be followed for assessing whether the child is in need of protective services.

Q: What happens when law enforcement is involved? Does the person end up in front of a judge and what actions can the judge take?
A: A key goal of the mobile crisis team is to de-escalate the situation so the person does not end up in jail or the emergency room. However, a person could become involved in the court

[4] E-mails from Melissa Higgins, Treatment Bureau Chief, DPHHS Behavioral Health and Developmental Disabilities Division. Dec. 6, Dec. 10, and Dec. 22, 2021.
[5] Discussion with Scott Malloy, Montana Healthcare Foundation. Dec. 6, 2021.
[6] Discussion with Terry Kendrick, Program Manager, Missoula Mobile Support Team. Dec. 30, 2021.

system if the person has committed a crime or poses a danger to self or others. If the person is believed to have committed a crime and enforcement activity is pursued, the matter would be handled under existing criminal laws. Those laws allow for an assessment of the person's mental state and provide options in terms of how the case is handled. If the person poses a danger to self or other, the person could be detained by law enforcement for evaluation and treatment by a mental health professional until the next regular business day. The professional person must file a report with the court on the actions taken and could ask the county attorney to initiate an involuntary commitment petition if the professional person believes commitment is necessary.

Q: Mr. Malloy described different short- and long-term crisis stabilization options in Billings. What organization is providing those services and what would be needed to expand that model?
A: The Billings Community Crisis Center provides short-term crisis services for a period of up to 23 hours and 59 minutes. Other communities in the state have created crisis stabilization facilities that allow for secure detention of people who pose a danger to themselves or others until the person is evaluated by a mental health professional to determine if commitment is warranted. The facilities also have other beds that are open to people who are voluntarily seeking services during a mental health crisis. Those stays generally last 5 to 7 days.

The state's recently developed Behavioral Health Crisis System Strategic Plan calls for the state to develop a crisis system that includes both short-term, outpatient crisis receiving services similar to the services offered by the Billings Community Crisis Center and longer-term crisis stabilization facilities similar to those that exist in some Montana cities. The strategic plan outlines several steps the state will take to implement the plan. (See DPHHS handout from November meeting.)

6. School-Based Health Centers[7]

Question Raised: How could more school districts be encouraged to designate schools as federally qualified health centers (FQHCs)?

Followup Information: The committee heard in November about the Montana Healthcare Foundation's School-Based Health Center Initiative and about the Bozeman School District's partnership with Intermountain, a mental health provider, and Community Health Partners, an FQHC. The two providers offer integrated physical and mental health care on site to students at two Bozeman high schools.

The high schools themselves are not designated FQHCs. Instead, an existing FQHC (in this case, Community Health Partners) identifies the school as a satellite site in a filing with its governing federal agency. The Health Resources and Services Administration of the U.S. Department of Health and Human Services oversees FQHC operations.

FQHCs can designate a school as a satellite site if:

- the FQHC is able to adequately staff the school-based health center; and
- the school has an appropriate space available to use solely for health center purposes or the FQHC has a mobile unit it can bring to the school site. If not using a mobile unit, a

[7] Discussion with Stacey Anderson, Jody White, and Lacey Alexander of the Montana Primary Care Association. Dec. 10, 2021.

school cannot be a satellite site unless it has a dedicated, designated room available for health center operations.

FQHCs face an additional challenge in providing school-based care because some services, are being performed by staff who typically aren't able to bill for their services. For example, services such as screenings, triage, and care coordination are often done by a registered nurse or behavioral health coordinator.

Several other school districts in Montana are partnering with FQHCs for school-based health centers similar to Bozeman. (See attached list from the Montana Primary Care Association.) The Healthcare Foundation's initiative, meanwhile, is designed to provide schools and FQHCs with technical assistance and funding to cover the planning and startup costs of opening a health center satellite at a school site. That initiative also is aimed at schools that meet certain criteria related to performance, graduation, or underperforming subgroups.

Schools also may partner with other health care providers to bring health care services into the school setting.