



MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Understanding the HEART Fund

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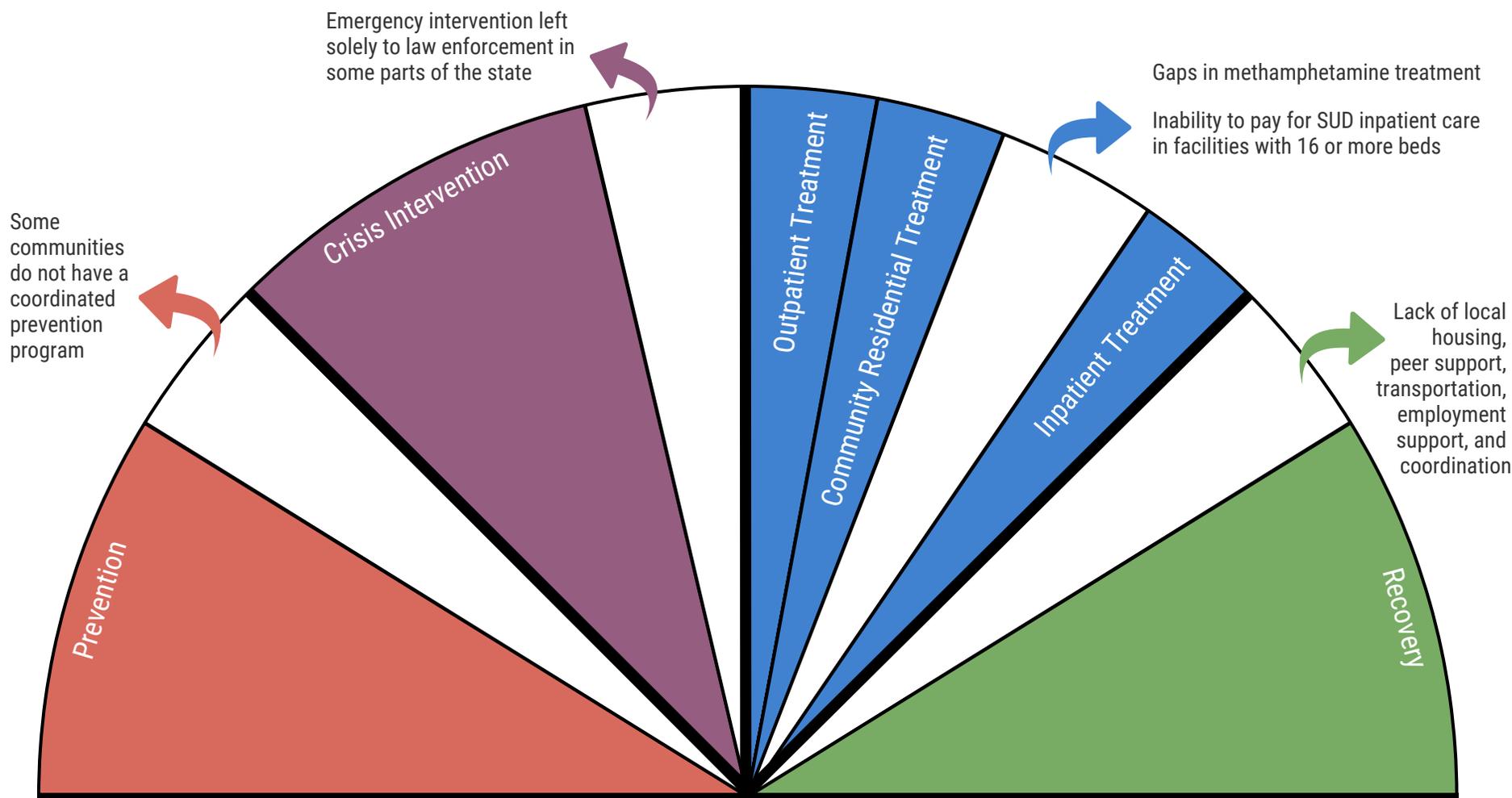
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MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Current: Before the HEART Fund

This graphic represents Montana's current model of substance use disorder (SUD) and behavioral healthcare. Gaps in the service continuum available to our local communities are represented by the missing segments in the figure below. The following pages illustrate how the Healing and Ending Addiction through Recovery and Treatment (HEART) Fund initiative will fill in the gaps, creating a more complete continuum of care.





MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Filling in the gaps through the HEART Fund

Prevention	Crisis Intervention	Treatment	Recovery
<ul style="list-style-type: none">• Resources for community-based prevention are doubled, allowing for stronger local coalitions and more evidence-based prevention practices.• Trauma-informed prevention programs for K-3 statewide.• Targeted prevention for substance-exposed youth• Universal substance use screening for youth in schools and primary care.• Vaping prevention and cessation for adolescents and young adults.	<ul style="list-style-type: none">• Community-specific activities intended to decrease the strain on law enforcement.• Increased number of communities with 24/7 access to mobile crisis response services.• First responders have additional resources for training and response capacity.• Montanans in crisis have access to services close to home, including regional medical crisis hubs.• Increase in crisis services provided by peers.	<ul style="list-style-type: none">• Tobacco cessation statewide as part of all treatment programs.• Specialized intensive outpatient treatment for parents with SUD.• Evidence-based methamphetamine treatment.• Increased resources for inpatient stays at larger community treatment facilities.• Integrated behavioral health in primary care settings, including emergency rooms.• Pharmacy, therapy, psychiatry, and substance abuse support transitions for jailed/incarcerated persons.	<ul style="list-style-type: none">• Peer support services integrated into additional settings.• Housing, peer support, transportation, and employment support are increased.• Coordination among non-clinical service providers.

See page 6 for more details

See page 8 for more details

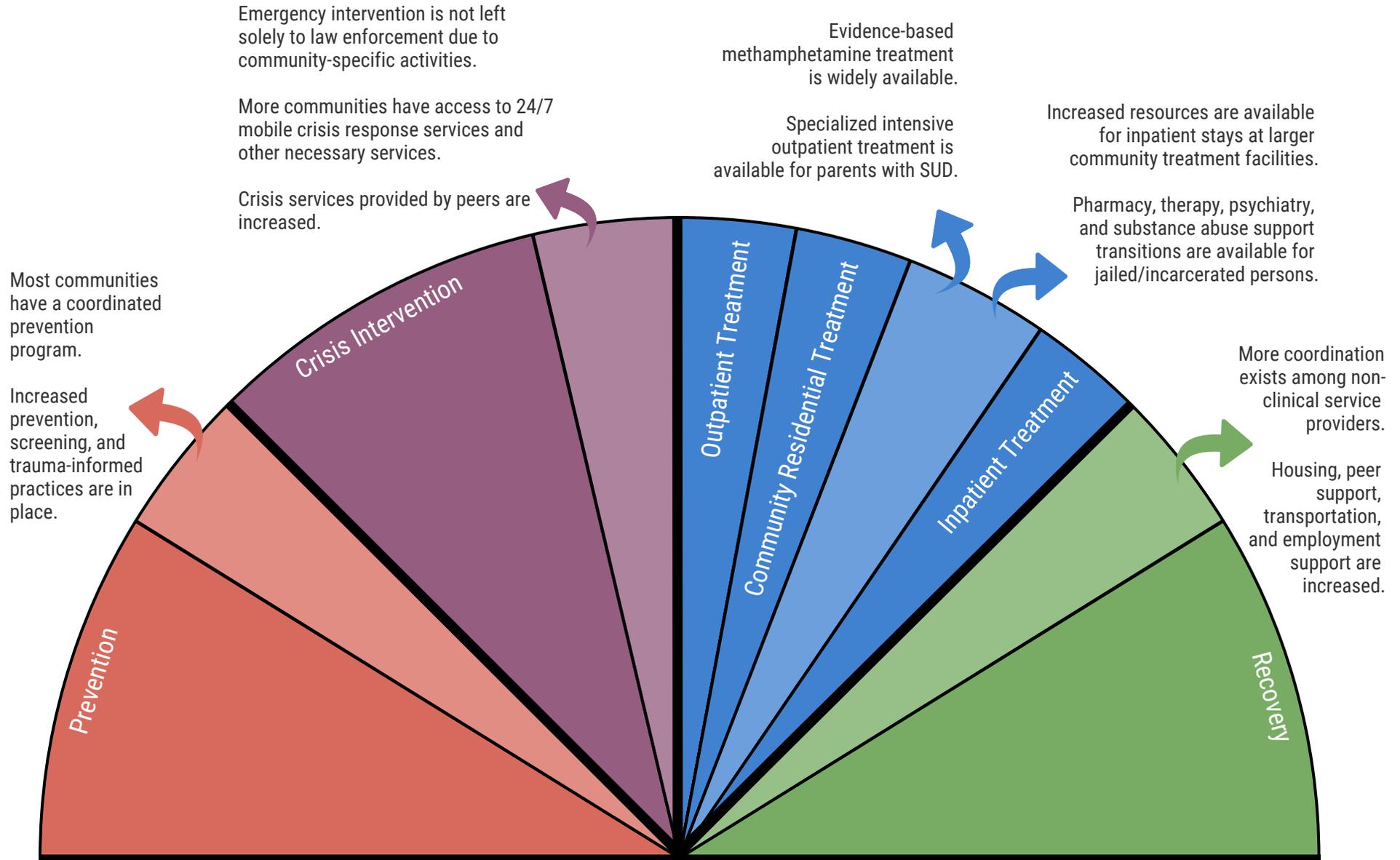
See page 10 for more details

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MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

After the HEART Fund





MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Funding the HEART Plan

The \$23.6 million HEART proposal includes \$6 million in state special revenue funds and associated federal Medicaid match. The HEART Plan has two components:

1. Improve utilization of existing funds.
2. Use and leverage HEART funds to improve the publicly funded continuum of care.

Montana must develop a behavioral health reform waiver through a community stakeholder engagement process to determine the final program design, including distribution of costs.

IMPROVING UTILIZATION OF EXISTING FUNDS

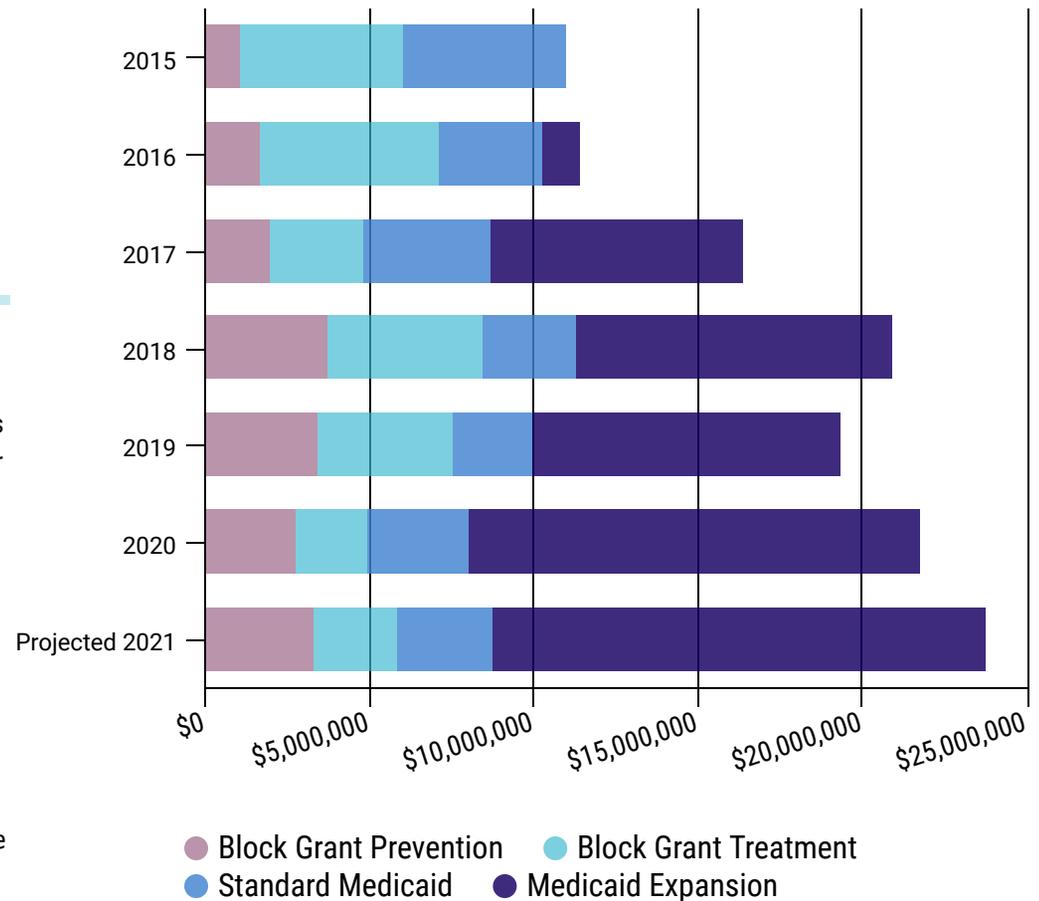
Prior to Medicaid Expansion, the federal Substance Abuse Block Grant paid for most of the publicly funded substance use disorder treatment in Montana. Montana receives about \$7 million per year through this block grant. Medicaid Expansion allows Montanans to access substance use disorder treatment, decreasing the amount of treatment paid for by the block grant. The amount of substance use disorder treatment paid through Medicaid has grown substantially over time with a concomitant decrease in block grant treatment funds (see graph on the right).

The HEART fund will allow the State to use block grant funding primarily for prevention and recovery moving forward because it allows the State to move most of the remainder of block grant treatment funds into Medicaid.

New block grant spending will include:

- \$3.5 million will fund community-based prevention. This will more than double the approximately \$3 million already being spent on community-based prevention.
- \$1 million will go to sustaining the PAX Good Behavior Game in elementary schools (see pages 6-7).
- Additional Coronavirus block grant funds will support HEART programs, including \$1.3 million to enhance housing initiatives.

Substance Use Disorder Expenditures by Funding Source



The above graph represents prevention and treatment services billed by our state-approved specialty SUD providers, but does not include other providers who may be providing outpatient SUD treatment services.



MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Funding the HEART Plan

Using and Leveraging HEART Funds to Create New Programs

\$6 million in new HEART funds will be used to fund the following programs:

- **Prevention:** Vaping (both tobacco and marijuana) is an epidemic among America's youth. \$500,000 in HEART funds will be used to directly support vaping prevention and cessation for youth and young adults.
- **Crisis Intervention:** Currently, most crisis intervention programs are funded through a state-local partnership grant program called the Crisis Diversion Grant Program (also called County and Tribal Matching Grants). This program allows local governments to use an in-kind match to set up best practice crisis services that meet a specific community's needs. \$1 million of the HEART fund will be used to replace general fund dollars in this program, resulting in an immediate savings to the general fund.
- **Treatment:** \$1.1 million of the HEART fund will be made available through grants to jails for necessary treatment including psychiatry, therapy, medication, and care coordination. Braided with the block grant funding, people who are leaving Montana's secure facilities will be more stable, healthier, and more ready to enter Montana's workforce.
- **Medicaid Services:** The remainder of the HEART fund will be used as a match for Medicaid. These funds will be used to assist the State in creating the proposed crisis, treatment, and recovery programs as outlined in pages 6 through 14. Adding in the federal Medicaid match brings the total to \$23.6 million.

The tables on the right detail the funding proposal. The block grant programs listed on page 5 are not included in this table for the sake of simplicity and because they are wholly federal funds.

HEART PROGRAMS	SFY 2022	SFY 2023
Vaping Prevention and Cessation	\$500,000	\$500,000
Continuity of Care in Jails	\$1,100,000	\$1,100,000
Medicaid:*		
• Crisis and Stabilization	\$1,900,000	\$1,900,000
• Early Intervention and Outpatient Treatment	\$6,100,000	\$6,400,000
• Community-Based Residential Treatment	\$5,100,000	\$5,500,000
• Inpatient Treatment	\$5,900,000	\$4,300,000
• Recovery Support	\$3,000,000	\$3,900,000
<i>Grand Total</i>	\$23,600,000	\$23,600,000

*These are estimates only. Development of a Medicaid behavioral health reform waiver requires stakeholder and federal involvement that is almost certain to impact the final amounts.

DISTRIBUTION OF HEART FUNDS	SFY 2022	SFY 2023
Crisis Diversion Grant	\$1,000,000**	\$1,000,000**
Vaping Prevention and Cessation	\$500,000	\$500,000
Continuity of Care in Jails	\$1,100,000	\$1,100,000
HEART Fund Medicaid (State portion)	\$3,400,000	\$3,400,000
Subtotal State HEART funds	\$6,000,000	\$6,000,000
Federal Medicaid Match***	\$18,600,000	\$18,600,000
General Fund offset for Crisis Diversion Grant	-\$1,000,000	-\$1,000,000
<i>Grand Total</i>	\$23,600,000	\$23,600,000

**This amount will be used to offset an equal amount in current general fund expenditures.

***The authority to leverage federal Medicaid match is not included in the amended HB 701.

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Current Prevention Model

PREVENTION PROGRAMS

Substance use can make daily activities difficult and impair a person's ability to work, interact with family, and fulfill other major life functions. Prevention activities help individuals avoid the use and misuse of drugs or the development of substance use disorders through education and support. Building resilience early in life is a protective factor leading to better mental health later in life.

Prevention work uses evidence-based strategies to reduce risk factors and enhance protective factors to improve the health and wellbeing of individuals, families, and communities.

CURRENT PREVENTION PROGRAMS

Regional technical assistance leaders:

Six highly-trained and experienced professionals who provide training and technical assistance to local specialists on community-based prevention strategies. The regional technical assistance leaders are aligned with the five healthcare planning regions and one full-time employee who supports the Indian reservations.

Community-based prevention:

Highly trained prevention specialists work at the community level to identify and implement effective prevention strategies to prevent substance use among youth and substance use disorders. Prevention specialists work with community coalitions to identify and address existing risk and protective factors, implementing evidence-based and best-practice strategies to reduce risk factors and strengthen protective factors in the community. Currently, 28 counties and five Indian reservations across the state have dedicated prevention specialists.

Communities That Care (CTC):

CTC is an evidence-based process that guides community coalitions to promote healthy youth development, improve youth outcomes, and reduce problem behaviors.

PAX Good Behavior Game:

PAX Good Behavior Game is an evidence-based approach to create a positive change in childhood behavior within the classroom and in the home setting by strengthening inhibition, promoting self-regulation, and improving social-emotional behaviors. PAX Good Behavior Game has impacted over 22,050 Montana students in 87 schools by training over 1,500 teachers and paraprofessionals. PAX means peace.

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Proposed HEART Prevention Model

POTENTIAL PREVENTION MODEL

1. Increase the number of counties and Indian reservations in Montana that have prevention specialists.
2. Increase the number of evidence-based coalition processes in more Montana communities. These may include Communities That Care, Collective Impact, or other evidence-based models of community choice.
3. Increase the number of schools implementing PAX Good Behavior Game or similar school-based/family-oriented evidence-based strategies that promote enhanced social-emotional behaviors and self-regulation.
4. Increase the number of evidence-based interventions focusing on community-based prevention.
5. Increase access to programs that address suicide and mental health prevention.
6. Increase the implementation of SBIRT (screening, brief intervention and referral to treatment) and other validated screening tools in local schools and primary care to address substance use and suicidal ideation.
7. Increase the number of evidenced-based interventions addressing the vaping epidemic among youth and young adults and access to cessation programs.

OUTCOME AND QUALITY MEASURES

The State will use these measurements to inform decision-making, aid in external reporting of services, and as tools for continuous evaluation and program improvement.

Increase prevention system capacity

- Total number of communities with prevention specialists
- Total number of communities with coalition coordinators
- Total number of PAX trainings and teachers trained

Increase availability of effective prevention interventions

- Total number of evidence-based interventions that address universal prevention
- Total number of evidence-based interventions that address selective and indicated prevention (for at-risk populations)
- Total number of evidence-based interventions that address shared risk and protective factors
- Total number of evidence-based interventions that address vaping (both nicotine and marijuana)

Decrease self-reported substance use/misuse by youth and adults in Montana

- Percent of youth who report alcohol, marijuana, nicotine, methamphetamine, and other substance use in last 30 days
- Percent of youth who report high risk behaviors (Prevention Needs Assessment data)
- Percent of adults who report binge drinking in past 30 days

Decrease utilization of emergency department admissions for substance use

- Total number of emergency department discharges by youth and adults for substance-related admissions

Increase availability of universal screening for at risk youth

- Total number of primary care facilities trained and implementing validated screening tools for substance and suicidal ideation
- Total number of schools trained and implementing screening tools

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Current & Potential HEART Crisis Intervention Model

CRISIS NOW

The Crisis Now model seeks to create a behavioral health crisis response system that ensures the provision of appropriate services to anyone, anywhere, anytime. The model identifies four key elements of a successful crisis system:

1. High-tech crisis call centers
2. 24/7 mobile crisis response
3. Crisis stabilization programs
4. Essential principles and practices: recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement

CURRENT CRISIS INTERVENTION THROUGH THE CRISIS DIVERSION GRANT

Purpose: Crisis Intervention and Jail Diversion ([MCA 53-21-1203](#))

Grants have funded:

- **Crisis System Capacity Building:** Trainings, community coordinator positions, data platforms and analysis, resource mapping, such as Sequential Intercept Mapping, strategic planning, and community collaboration.
- **Crisis Intervention Team (CIT):** Trainings for law enforcement and first responders, coordination of CIT efforts within communities, interventions availability for rural and frontier communities.
- **Jail-Based Services:** Jail-based therapy, case management, care coordination, and medication prescription and administration services.
- **Mobile Crisis Response Services:** Crisis response team services, co-responders and mobile crisis response teams.
- **Crisis Stabilization Services:** Outpatient and inpatient crisis stabilization services.
- **Infrastructure:** Bricks-and-mortar development and expansion of crisis receiving and stabilization facilities.

POTENTIAL CRISIS INTERVENTION MODEL

Some services currently funded through the Crisis Diversion Grant could be developed into a Medicaid-reimbursement model – enhancing service coordination and quality monitoring, increasing the impact of State dollars, and supporting statewide implementation of the Crisis Now model.

Montana Medicaid Funded Services

- **Mobile Crisis Response Services:** Mobile crisis response teams respond to anyone, anywhere, anytime in order to divert individuals from law enforcement, jails, and emergency rooms.
- **Crisis Stabilization Services:** Outpatient and inpatient crisis stabilization services support the development and sustainability of appropriate and alternative locations for individuals experiencing a behavioral health crisis.
- **Detention Center Transition Services:** These services facilitate successful transitions from detention centers to community-based settings to ensure continuity of care and the provision of adequate supports to reduce recidivism.

Crisis Diversion Grant

Crisis Diversion Grant dollars could continue to fund current crisis system capacity building and CIT, particularly in rural and frontier communities, as well as initiatives that further the statewide implementation of Crisis Now infrastructure.

- **Bed Board:** Statewide bed board to facilitate timely referrals and placements for individuals requiring inpatient psychiatric services to reduce wait times in emergency rooms and unnecessary transports to the Montana State Hospital.
- **Bricks-and-Mortar:** Develop or expand crisis receiving and stabilization facilities.

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Proposed HEART Crisis Intervention Model Outcomes

OUTCOME AND QUALITY MEASURES

The State would use quality measurements to inform decision-making, aid in external reporting of services, and as tools for continuous evaluation and program improvement. Additionally, these measures could ultimately assist in the development of pay-for-performance payment models.

Increase crisis system capacity

- Total number of communities with crisis system coalitions
- Total number of communities with crisis system coordinators
- Total number of communities with completed crisis system resource mapping
- Total number of communities with crisis system strategic plans

Increase implementation of Crisis Intervention Team (CIT)

- Total number of CIT communities

Increase availability of crisis services

- Total number of communities and/or regions served by a mobile crisis response team
- Total number of individuals served by a mobile crisis response team
- Total number of communities and/or regions served by an outpatient crisis receiving facility and/or inpatient crisis stabilization facility
- Total number of individuals served by an outpatient crisis receiving facility and/or inpatient crisis stabilization facility

Increase the utilization of Certified Behavioral Health Peer Support Specialists (CBHPSS) within crisis services

- Total number of CBHPSS providing services on mobile crisis response teams
- Total number of CBHPSS providing services at crisis receiving and stabilization facilities
- Total number of CBHPSS providing services at emergency departments

Increase availability of detention center transitional services

- Total number of behavioral health providers serving individuals during their transition out of a detention center

Decrease detention center recidivism rates for individuals with behavioral health diagnoses

- Total number of individuals with a behavioral health diagnoses who return to a detention center within an established timeframe (e.g. 6 months, 1 year)

Decrease utilization of law enforcement response and jails for behavioral health crisis intervention

- Total number of behavioral health-related responses from law enforcement
- Total number of individuals booked into a jail with an acute behavioral health diagnosis

Decrease utilization of emergency medical services and emergency rooms for behavioral health crisis services

- Total number of behavioral health-related responses from emergency medical services
- Total number of individuals accessing emergency rooms for behavioral health crisis services

Decrease in admissions and readmissions to acute inpatient settings

- Total number of individuals admitted to an inpatient psychiatric setting for a short-term stay of fewer than seven days

Decrease in admissions and readmissions to the Montana State Hospital

- Total number of individuals admitted to the Montana State Hospital for a short-term stay of fewer than seven days

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Current SUD Treatment Model

THE AMERICAN SOCIETY OF ADDICTION MEDICINE CRITERIA

The American Society of Addiction Medicine (ASAM) provides standardized treatment criteria for substance use disorder and co-occurring conditions. The ASAM criteria describe different levels of care with specific service and recommended provider requirements to meet the needs of individuals. The ASAM levels span from 0.5 (early intervention) to 4.0 (hospitalization). Montana Medicaid develops and approves its treatment models based on this national standard.

CURRENT SUD TREATMENT CONTINUUM OF CARE

Purpose: Comprehensive program for treatment (MCA 53-24-207)

SUD Early Intervention (ASAM 0.5):

Services targeted to individuals at risk of developing a substance-related problem, but who may not have a SUD diagnosis.

Montana Medicaid covered services: assessments, screening, SBIRT (screening, brief intervention, and referral to treatment).

SUD Outpatient (ASAM 1.0):

Treatment services provided fewer than 9 hours per week for adults and fewer than 6 hours per week for adolescents.

Montana Medicaid covered services: individual/group/family therapy, targeted case management, certified peer support services. Block grant covered services: educational groups.

SUD Intensive Outpatient (ASAM 2.1):

Treatment services intended to be provided more than 9 hours per week for adults and more than 6 hours per week for adolescents.

Montana Medicaid covered services: bundled service package which includes individual/group/family therapy, educational groups, psychosocial rehabilitation, co-occurring mental health, face-to-face crisis services, and face-to-face care coordination.

SUD Partial Hospitalization (ASAM 2.5):

Treatment services provided a minimum of 20 hours per week and direct access to psychiatric, medical, and laboratory services on-site.

Montana Medicaid covered services: bundled service package which includes individual/group/family therapy, psychosocial rehabilitation.

SUD Clinically Managed Low Intensity Residential (ASAM 3.1):

24-hour residential support and structure with at least 5 hours of clinical services per week.

Montana Medicaid Covered services: individual/group/family therapy, targeted case management, certified peer support services. Block grant covered services: room and board, psychosocial rehabilitation (skills building).

SUD Clinically Managed High Intensity (Adult) & Medium Intensity (Adolescent) Residential (ASAM 3.5):

24-hour care with trained counselors for individuals whose substance-related issues are significant enough to require a 24-hour treatment setting to prepare for a less intensive level of care in the community.

Montana Medicaid covered services: bundled service package which includes individual/group/family therapy, and psychosocial rehabilitation.

SUD Medically Monitored Intensive Inpatient (ASAM 3.7):

24-hour evaluation, observation, and medical monitoring with nursing interventions and physician availability. Counselors are also available to provide SUD treatment.

Montana Medicaid covered services: bundled service package which includes individual/group/family therapy, nurse intervention and monitoring, and psychosocial rehabilitation.

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Proposed HEART SUD Treatment Model

PROPOSED SUD TREATMENT MODEL

Montana Medicaid proposes to enhance the SUD Continuum of Care by adding the following services:

30-day residential/inpatient IMD (Institutions for Mental Disease) stays:

Request a federal waiver to use Medicaid to pay for patients in mental health or substance use disorder residential/inpatient facilities with 16 beds or more. This service will reduce the numbers of individuals on waiting lists at current non-IMD facilities.

Treatment of Users with Stimulant Use Disorder (TRUST):

Treat individuals with stimulant use disorders with the following best practices: motivational interviewing, contingency management, community reinforcement approach, and cognitive behavioral therapy. The expected positive outcomes of this evidence-based treatment include reduction in stimulant use, risky behaviors, and mental health symptoms.

Specialized treatment for pregnant women and parents:

Support and track implementation of best practices to address the unique needs of pregnant women and parents. This approach will improve the quality of care and allow for incentivized rates based on positive outcomes. To access this add-on service, behavioral health professionals would be required to receive specialized training for this population. Services must be individualized and could include parenting classes, vocational services, tenancy support, peer support, family education, and others as identified.

Evidence-based assessment tool:

Utilize a standard structured clinical interview for assessing adults and adolescents with SUD to provide clinically appropriate care. This tool would be used across providers for all levels of care.

Tobacco cessation in all treatment programs:

Combines tobacco cessation with behavioral health to increase the odds of long-term recovery, mental and physical health benefits, and a client's sense of mastery and focus on a positive lifestyle.

CLOSING THE GAPS IN THE SUD CONTINUUM OF CARE

SUD Clinically Managed Residential Withdrawal Management (ASAM 3.2-WM):

24-hour supervision, observation, and support for individuals who need 24-hour support to complete withdrawal management and increase their likelihood of continuing treatment or recovery. This level of care can be very helpful for those withdrawing from methamphetamine.

SUD Clinically Managed Population Specific High Intensity Residential (Adult only) (ASAM 3.3):

24-hour care with trained counselors for individuals with significant cognitive impairments resulting from substance use or other co-occurring disorders who need a slower paced, more repetitive treatment.

SUD Early Intervention (ASAM 0.5):

Targeted services for youth who are at risk of developing substance-related problems, or a service for those for whom there is not yet sufficient information to document a diagnosable substance use disorder.

SUD Medically Managed Intensive Inpatient Services (ASAM 4.0):

24-hour nursing care and daily physician care for severe, unstable problems. Counseling is available 16 hours a day to engage patients in treatment.

State Approval: Increase access to ASAM 4.0 by allowing accredited hospitals, certified federally qualified health centers, rural health clinics, and Indian Health Services/Tribal 638, with verification of adherence to federal regulations to become state approved for ASAM 4.0 services.

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Proposed HEART SUD Treatment Model

OUTCOME AND QUALITY MEASURES

The State will use these measurements to inform decision-making, establish baseline, aid in external reporting of services, and as tools for continuous evaluation and program improvement on our capacity to implement SUD treatment services in Montana Medicaid.

Evidence-based outcome measurement tool:

Utilize a research-backed tool across providers and services to collect client level outcome data to evaluate the effectiveness of SUD services. The Daily Living Activities-20 (DLA-20) is currently being used for SUD IOP (ASAM 2.1) and could be expanded for use in other appropriate levels of care where the length of stays are at least 30 days.

MEASURE #1: 7-day follow-up after withdrawal management

The number of patients receiving treatment within 7 days of withdrawal management over the total number receiving withdrawal management (ASAM 3.3 and higher). This measure assesses the extent to which patients initiate treatment within 7 days after receiving withdrawal management services.

MEASURE #2: Presence of screening for psychiatric disorder and suicidality

a. The number of patients screened using an evidence-based tool for mental illness over the total number of patients reporting with symptoms of mental distress (all settings treating SUD).

b. The number of patients screened using an evidence-based tool for suicidality over the total number of patients (all settings).

This measure assesses the extent to which patients are formally assessed for a psychiatric diagnosis.

MEASURE #3: Presence of screening for tobacco use disorder in SUD treatment settings

The number of patients presenting for SUD treatment over the total number of patients (all settings treating SUD). This measure assesses the extent to which patients with an SUD diagnosis, receiving addiction treatment, are screened for a tobacco use disorder diagnosis.

MEASURE #4: Presence of screening for a substance use disorder

The number of patients presenting with mental distress, accident, or poisoning who are screened using an evidence-based assessment for SUD over the total patients presenting with mental distress, accident, or poisoning (all acute care settings). This measure assesses the extent to which individuals presenting with evidence of a possible SUD are screened for that disorder.

MEASURE #5: Primary care visit follow-up

The number of patients being treated for SUD or mental illness who receive a primary care visit annually over the number of patients being treated for SUD or mental illness (all specialty SUD and mental health settings). This measure identifies the proportion of individuals who have a primary care visit after an SUD treatment encounter, and assesses the extent to which clinicians assure comprehensive patient care.

MEASURE #6: All cause inpatient, residential re-admission

The number of patients re-admitted within 30 days of discharge. This measure is used to assess the rate of all-cause unplanned readmissions, 30 days following an initial episode of residential/inpatient SUD treatment, and assesses the clinician's management of the patient's entire medical condition.

MEASURE #7: Referral from acute care settings

The number of patients who received specialty SUD or mental health care following referral from an acute or primary care setting over the number referred. This measure assesses the availability of specialty SUD and mental health care services statewide.

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Current SUD Recovery Model

RECOVERY SUPPORT

According to the Substance Abuse and Mental Health Administration (SAMHSA), “Recovery-oriented care and recovery support systems help people with mental and substance use disorders manage their conditions successfully. Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.”

CURRENT RECOVERY SUPPORT SERVICES & PROGRAMS

Certified Behavioral Health Peer Support Services (CBHPSS):

Coaching to restore skills, support self-advocacy, mitigate crisis or relapse, facilitate the use of community resources, and restore natural supports. Services are paid by Montana Medicaid.

Community Maintenance Program (CMP):

Medication and community support for Montana Medicaid members who require long-term, ongoing assistance at a higher level than traditional outpatient services.

Drop-in centers:

Peer-operated program for consumers to gather for socialization, crisis mitigation, consumer-run services, and other needed mental health, co-occurring, or community resources.

Supported employment:

Employment services for individuals with SDMI that may include integrated mental health treatment, personalized benefits planning, and continuous follow-along work supports. Individuals work with employment specialists who are part of a multidisciplinary team that meets regularly to review individual progress, and provide ongoing guidance regarding Social Security, Medicaid, and other government programs.

Care coordination:

Expands current case managers’ capacity in health care navigation, builds on existing skills in health behavior change, and requires a better understanding of the common health problems and basic interventions for individuals with serious mental illness, substance use disorders, and those with chronic health problems. Services ensure members receive the right care at the right time by coordinating services and referrals, tracking clinical outcomes, identifying barriers to recovery (e.g. housing, transportation, food insecurity), and navigating community resources.

The current Montana Medicaid programs with care coordination incorporated into the program design are the Program for Assertive Community Treatment (PACT), Behavioral Health Group Homes, and Intensive Outpatient Treatment.

Tenancy support services:

Direct support and assistance with activities and processes associated with an individual's preparation for and transition to housing. Service is made available to support individuals to maintain tenancy once housing is secured. The availability of ongoing housing related services in addition to other long-term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support networks.

The current Montana Medicaid program that has tenancy services incorporated into the program design is PACT.

MONTANA SUBSTANCE ABUSE CONTINUUM OF CARE

Proposed HEART SUD Recovery Support Model

PROPOSED RECOVERY SUPPORT

The State proposes to enhance recovery support by adding the following:

Care coordination and tenancy support services:

Expand evidence-based and best practice care coordination and tenancy support services and programs to address the unique needs of individuals living with mental illness and substance use disorders.

OUTCOME AND QUALITY MEASURES

Recovery support encourages the least restrictive level of care and reduce hospitalizations. This will provide data on statewide availability of services and allow for the monitoring of transitions between levels of care.

Evidence-based outcome measurement tool:

Utilize a research-backed tool to evaluate the long-term effectiveness of SUD services. The Daily Living Activities-20 (DLA-20) will continue to be used into recovery.

MEASURE #1: Decrease 30-day acute inpatient readmission rates for individuals with a severe and disabling mental illness.

Decrease in admissions/readmissions to acute inpatient settings. Track the utilization for acute, emergency department, and involuntary commitments to establish a benchmark for decreases in utilization in the first year of implementation. Then once a benchmark is established, set a target to reach for decreased utilization.

MEASURE #2: Increase housing stability.

Percentage of days a member was in independent housing.

MEASURE #3: Increase integration with primary care.

Percentage of members who had an outpatient visit with a primary care provider annually.

MEASURE #4: Community integration.

Temple University, Peer Facilitated Community Inclusion Toolkit Community Participation Measure, as modified. Percentage of members who had this completed with them every 90 days by CBHPSS.

Track community participation to establish a benchmark for increased inclusion in the first year of implementation. Then once a benchmark is established, set a target to reach increased community integration.