Montana

UNIFORM APPLICATION
FY 2022/2023 Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 03/02/2022 - Expires 03/31/2025
(generated on 02/08/2023 2.31.40 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year	2022
End Year	2023

State DUNS Number

Number	051659352
Expiration Date	3/14/2022

I. State Agency to be the Grantee for the Block Grant

Agency Name	Montana Department of Public Health and Human Services
Organizational Unit	Behavioral Health & Developmental Disabilities Division
Mailing Address	PO Box 202905
City	Helena
Zip Code	59620-2905

II. Contact Person for the Grantee of the Block Grant

First Name	Mary
Last Name	Collins
Agency Name	Montana Department of Public Health and Human Services
Mailing Address	PO Box 202905
City	Helena
Zip Code	59620-2905
Telephone	406-444-9635
Fax	406-444-9389
Email Address	Mary.Collins@mt.gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	10/1/2021 5:18:59 PM
Revision Date	1/10/2023 9:50:24 AM

V. Contact Person Responsible for Application Submission

First Name	Jami
Last Name	Hansen
Telephone	406-444-3055
Fax	406-444-9389
Email Address	Jami.hansen@mt.gov

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
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Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
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Section 1943	Additional Requirements	**42 USC § 300x-53**
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Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Adam Meier

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

OFFICE OF THE GOVERNOR
STATE OF MONTANA

GREG GIANFORTE
GOVERNOR

KRISTEN JURAS
LT. GOVERNOR

August 18, 2021

Ms. Odessa Crocker
Grants Management Officer
Division of Grants Management
5600 Fishers Ln
Rockville, MD 20857

Re: Funding Agreement for Certifications and Assurances SABG and MHBG

Dear Ms. Crocker,

In my capacity as Governor of the State of Montana, I designate Adam Meier, Director of the Department of Public Health and Human Services, the authorizing official to the Community Mental Health and Substance Abuse Prevention and Treatment Block Grants under Title XIX Part B, Subpart II and III of the Public Service Act.

Adam has my authority to plan, distribute funding, report, sign funding agreements and certifications, provide assurances of compliance to the Sectary, and perform similar acts relevant to the administration of these Block Grants until such time as this delegation of authority is rescinded.

Sincerely,

Greg Gianforte
Governor

STATE CAPITOL • P.O. BOX 200801 • HELENA, MONTANA 59620-0801
TELEPHONE: 406-444-3111 • FAX: 406-444-5529 • WEBSITE: WWW.MT.GOV

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 3)
Fiscal Year 2020/21

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements as required by Substance Abuse Prevention and Treatment Block Grant Program as authorized by
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State: Montana

Name of Chief Executive Officer (CEO) or Designee: Adam Meier

Signature of CEO or Designee[1]:

Title: Director Date Signed: 8-24-2021
mm/dd/yyyy

1 If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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7. U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply eall interests in real property acquired for project purposes regardless of Federal participation in purchases.

9. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

10. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction sub agreements.

11. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

12. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

13. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

14. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

15. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

16. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

17. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

18. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

19. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Bobbi Perkins

Title

Bureau Chief

Organization

State of Montana - DPHHS

Signature: Date:

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

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State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Bobbi Perkins

Title

Bureau Chief

Organization

State of MT / DPHHS / AMDD

Signature: Bobbi Perkins Date: 8.25.21

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

MONTANA - SABG FY 2022-23 APPLICATION

PLANNING STEP 1

October 01, 2021

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SAFETY

Addictive and Mental Disorder Division

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PLANNING STEP 1
MONTANA - SABG FY 2022-2023
Application

Assess the strengths and organizational capacity of the service system to address the specific populations

Montana Overview

Geographically, there are 145,545.80 square miles, or 7.45 people per square mile, called "Montana". This vast land area is divided among 56 counties - 10 counties deemed "rural", and 46 counties deemed "frontier." These frontier counties in Montana include 8 Native American Tribes and 7 Reservations. A county is typically deemed "frontier" when the population density is 6 or less people per square mile. The distribution of our population (1,084,225) drives funding for all services. Little less than half of Montana's population is in 7 cities. Billings is the only city with a population of over 100,000 people. The demographic of our population is as follows.

Race

88.9% White, 6.7% American Indian and Alaska Native, 2.8% Two or more races, 1.6% All other races combined

Gender

49.7% Female, 50.3% Male

Education

93.6% High School Graduate, 32.0% Bachelor's Degree or higher,

Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services.

The Department of Public Health and Human Services Structure
The Department of Public Health and Human Services (DPHHS) under the Executive Branch of Montana State Government, administers a wide spectrum of programs and projects including public assistance, Medicaid, foster care and adoption, nursing home licensing, long-term care, aging services, alcohol and drug abuse programs, mental health services, vocational rehabilitation, disability services, child support enforcement activities, and public health functions (such as communicable disease control and preservation of public health through chronic disease prevention).

DPHHS mission: Improving and protecting the health, well-being, and self-reliance of all Montanans.

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the public chemical dependency services for children and adults under the Division of Addictive and Mental Disorders as described below in more detail.

Oversight of the divisions is organized into Branches:

Economic Security Services Branch: Provides direct supervision over the Human and Community Services Division, Child Support Enforcement Division, Child and Family Services Division, and the Disability Employment and Transitions Division. The branch delivers a broad range of social services to communities in Montana. The branch manager develops an organized approach to family economic security, assists with interdepartmental issues such as system development and tribal relations and develops strategies to manage scarce resources.

Medicaid and Health Services Branch: Provides direct supervision over the Senior and Long-Term Care Division, Developmental Services Division, **Addictive and Mental Disorders Division**, Health Resources Division, the Medicaid Systems Support Program, and the Healthy Montana Kids Program. The branch provides medical, rehabilitative, and mental health services for Montanans through a variety of programs. The branch manager oversees and coordinates programs and activities of the branch and, as the state Medicaid Director, establishes policy for the Montana Medicaid program.

Operations Services Branch: Provides direct supervision over the Business and Financial Services Division, Quality Assurance Division, Technology Services Division, Office of Budget and Finance, and Office of Fair Hearings. The branch manager develops policy on major issues affecting operations and, as the chief operating and chief financial officer, is responsible for the department's budget, finance, technology, and oversight activities.

DPHHS Divisions provide assistances, services, and support outside of children and adult chemical dependency services. A brief description of the relevant divisions' scopes of authority are listed below:

The Addictive & Mental Disorders Division provides for the implementation and improvement of statewide systems of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol. AMDD through the Mental Health Services Bureau is responsible for the development and management of the adult mental health system (age 18 and over). The Division provides chemical dependency and adult mental health services by contracting with providers throughout Montana. It also provides services through three inpatient facilities-the Montana State Hospital in Warm Springs, Montana Chemical Dependency Center in Butte, and Montana Mental Health Nursing Care Center in Lewistown.

The Child and Family Services Division provides state and federally mandated protective services to children who have been or are at substantial risk to be abused, neglected, or abandoned. This includes receiving and investigating reports of child abuse and neglect, working to prevent domestic violence, helping families to stay together or reunite, and finding placements in foster or adoptive homes. Many children served by this Division receive public chemical dependency services.

The Child Support Enforcement Division provides federally mandated child support enforcement services. These include locating absent parents, establishing paternity, establishing financial and medical support orders, enforcing current and past-due child support, offering medical and spousal support, and modifying child support orders.

The Developmental Services Division provides for two primary programs: the Developmental Disabilities Program and the Children's Mental Health Bureau. The Developmental Disabilities

Program contracts with private, non-profit corporations to provide services across the lifespan for individuals who have developmental disabilities and their families. The focus of the program is to tailor care to the individual and provide it in as natural environment as possible. The Montana Developmental Center is administered by the Disabilities Services Division and is the State's only residential facility for individuals with developmental disabilities that provide 24-hour care for those with the most severe behaviors or severe self-help deficits. The Children's Mental Health Bureau provides care and support to individuals under 18 years of age who have been diagnosed with serious emotional disturbance (SED).

The Disability Employment and Transitions Division is charged to advance the employment, independence, and transitions of Montanans with disabilities. Disability Employment and Transitions offers a variety of services, ranging from employment planning to transportation coordination. Disability Employment and Transitions also works with a variety of other agencies to reduce barriers for people with disabilities so that all Montanans can be free to fulfill their potential and contribute to their communities. This work is accomplished through the following programs: Blind and Low Vision Services Division, Vocational Rehabilitation, Independent Living, Disability Determination Services, Montana Telecommunications Access Program, and ASPIRE Montana Program.

Health Resources Division (HRD) administers Medicaid primary care services, Healthy Montana Kids, Children's Health Insurance Plan, and Big Sky Rx. The purpose of the division is to improve and protect the health and safety of Montanans. The division reimburses private and public providers for a wide range of preventive, primary, and acute care services. Major Service providers include physicians, public health departments, clinics, hospitals, dentists, pharmacies, durable medical equipment, and mental health providers

The Human and Community Services Division's mission is to support the strengths of families and communities by promoting employment and providing the assistance necessary to help families and individuals meet basic needs and work their way out of poverty. They accomplish this by providing cash assistance, employment training, food stamps, Medicaid, childcare, meal reimbursement, nutrition training, energy assistance, weatherization, and other services to help families move out of poverty and toward self-support.

The Public Health and Safety Division oversees the coordination of the public health system in Montana. The Division mission is to: Improve and protect the health of Montanans by creating conditions for health living. Services range in scope from nutrition support and health education (e.g., WIC & Tobacco Use Prevention) to screening services (e.g., breast & cervical cancer screening programs for uninsured women and HIV counseling & testing services) to preventive services (e.g., immunization) and surveillance systems for infectious and chronic diseases, designed to detect and target those health threats that may impact a community.

The Quality Assurance Division provides a variety of services that integrate in multiple divisions within the Department of Public Health and Human Services. Such services include certifying health care services, licensing health care and residential care, licensing childcare, detecting, and investigating abuse and fraud, performing quality control reviews, providing internal and independent audits, determining medical necessity, maintaining a certified nurse aide training program, managing the marijuana program registry, implementing the certificate of need program, and ensuring department compliance with HIPPA.

The Senior and Long-Term Care Division manages a wide variety of programs and services guided by their missions: To advocate and promote dignity and independence for older Montanans and Montanans with disabilities. The Division helps people who are aged or disabled and who have limited income and resources remain in their homes, rather than receive services in a hospital or nursing facility. The Division operates within a cost-effective service delivery system that provides information on how participants can live healthy lives, access housing options that provide least restrictive options, and provide protective or legal services. The Division also operates and manages two Veterans' Homes for those who have served their country and spouses of veterans.
Printed:

Attached is a copy of the DPHHS Organizational Chart updated May 11th, 2021.

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems.

Addictive and Mental Disorders Division

Montana is fortunate as both the substance use disorders treatment system, and the adult mental health system is located under the Addictive and Mental Disorders Division within the Department of Public Health and Human Services. The SSA/SMHA provides all direction for the mental health and substance use disorders prevention, early intervention, treatment, and recovery support services. The SSA/SMHA works within all the other Divisions and programs within DPHHS to develop partnerships needed to address issues of those in treatment for mental health and substance use disorders.

Montana AMDD provides for the establishment and implementation of a continuum of care to provide for individuals with substance abuse disorders, including those with co-occurring mental illness and substance abuse disorders. Available services and resources within Montana's comprehensive continuum of care are provided primarily with federal resources and have some state resources. AMDD is responsible for managing reimbursement for Medicaid and other federal and state funded services for SUD and is working towards integration of SUD and adult mental health services. AMDD recently restructured to include both SUD and adult mental health treatment services under one bureau.

Montana's substance use disorders treatment system does not differ between the youth (child) and adult systems. To provide a complete continuum of care, AMDD has contacted 26 providers to administer SUD services to individuals regardless of age. Additionally, 41 state-approved providers throughout Montana have been invited to contract with the department. Providers are required to identify evidence-based practices to address age, race, ethnicity, priority populations, etc. as part of their treatment programming and continuation application for funding. Based upon the population within their coverage area, providers will identify the populations served and what evidence-based programing to be used. For instance, providers addressing women with dependent children use Seeking Safety as appropriate practice.

Types of Services

Prevention Services

- **Community-Based Substance Misuse and Abuse Prevention**: Universal strategies that help prevent children and youth from using substances as well as targeted interventions to help at-risk populations from misuse and abuse of substances. Community-based prevention promotes public health and coalition-based approaches to prevention strategies. AMDD currently pays for prevention specialists in the majority of Montana's counties.

- **Parenting Montana**: A web-based prevention resource for parents that braids together support grounded in evidence-based practices to help kids and families thrive, with specific goals to cultivate a positive, healthy culture among Montana parents with an emphasis on curbing underage drinking; provide resources to engage parents or those in a parenting role; and provide tools for everyday parenting challenges from the elementary to post high school years. Parents and children learn how to grow skills such as self-awareness, self-management, responsible decision-making, relationship skills, and social awareness.

Parents can use these approaches with their children as they mature. Developing social and emotional skills protects children from negative outcomes associated with adverse childhood experiences (ACEs) and bolsters resilience.

- **Communities That Care (CTC)**: An evidence-based approach to guide communities through a proven five-phase change process. Using prevention science as its base, CTC promotes healthy youth development, improves youth outcomes, and reduces problem behaviors. Planning for this program began in January 2018 and the project's vision is to engage in a five-phase community change process that helps reduce levels of youth behavioral health problems before they escalate; a path to get away from the cycle of reaction.

- **Alcohol Compliance/Reward and Reminder**: Federal funds are allocated to ensure retailers follow the laws preventing youth access to alcohol. Through the Alcohol Compliance / Reward and Reminder Program, compliance visits are conducted throughout communities to provide educational opportunities for retailers to train staff on the laws, ensure clerks and bartenders are checking for valid identification and to be rewarded when compliance is achieved.

- **Tobacco 21/Synar and FDA Tobacco Compliance**: The Code of Federal Regulations requires States to perform tobacco compliance inspections to ensure tobacco retailers are following state and federal regulations in not selling tobacco products to minors. Montana current rate is 3.3% in retailer violations.

Early Intervention Services

- **Prime For Life**: Designed for first time DUI or any MIP citation. The program focuses on alcohol and marijuana effect on the brain and body, covers MT law, and incorporates behavior change principles to prevent future DUI and MIPs. Those addressing MIP's (Minor's in Possession) use the 8-hour version of Prime For Life with the focus on youth whereas the adult DUI (Driving Under the Influence) use the 12 hours version of Prime For Life. Assessment instruments are identified and used based upon truth indicators and age.

- **First Episode Psychosis**: An evidence-based program for identifying an initial psychosis episode in youth and young adults, ensuring early treatment services and support services to the individual and family. First Episode Psychosis programs have been shown to be highly effective in reducing or ameliorating adult psychosis, so much so that AMDD is mandated to cover them.

Crisis Intervention Services

- **Naloxone Training and Access to Medication**: Under the State Opioid Response grant, training on how to use and administer Naloxone is available free of charge. EMS, law enforcement, school nurses, harm reduction clinics, families, and individuals can access Naloxone through this program.

- **County and Tribal matching grants for crisis intervention and jail diversion**: These grants allow the coordination of several critical stakeholders including hospital systems,

primary care providers, behavioral health providers, first responders, law enforcement, justice systems, and social service programs to meet local community needs.

- **The 72-hour program for presumptive eligibility**
- **Secure crisis beds in crisis diversion facilities**

Treatment Services

- **Psychiatry and medication management**
- **Illness management and recovery**
- **SUD and mental health treatment homes**
- **Individual and group therapy**
- **Psychiatric rehabilitation and support**
- **High intensity services for those with severe illnesses including Program of Assertive Community Treatment, and Intensive Outpatient Treatment for Substance Use Disorder**
- **Inpatient hospitalization**
- **TRUST model SUD treatment pilot program**: A new pilot program to enhance stimulant use disorder treatment among SUD treatment programs. This pilot will combine evidence-based interventions including contingency management, community reinforcement, exercise, and cognitive behavioral therapy.
- **SUD Intensive Outpatient (SUD IOP)**: Recently, AMDD implemented a comprehensive service package for SUD IOP. This service package has two tiered per-diem rates for adults, one tier for adolescents, and an enhancement add-on for mental health integration. This reimbursement model promotes individualized treatment planning consistent with the American Society of Addiction Medicine's (ASAM) Criteria for this level of care while increasing statewide access to SUD intensive outpatient services. SUD IOP is a model that Montana's drug courts have embraced as an alternative to incarceration.
- **Program of Assertive Community Treatment (PACT)**: An established, evidence-based program that uses an interdisciplinary team of trained professionals to provide treatment in a community setting to adults with chronic mental illness. This includes assertive outreach, mental health treatment, health, vocational, integrated dual disorder treatment, family education, wellness skills, care management, tenancy support, and peer support from a mobile, multidisciplinary team in community settings. In addition, Montana Assertive Community Treatment (MACT) was created to provide outreach to rural and frontier areas which acknowledges the staffing challenges, as well as the distance faced in rural and frontier communities.
- **The Montana State Hospital**: MSH serves Montana via civil commitments, involuntary commitments, emergency detentions, or court ordered placements. The hospital also aids the Montana legal system by providing forensic evaluations to the courts of Montana. It is

the only federally certified adult psychiatric hospital in the state, and it designs treatment planning around the individual needs of each patient, combining medical, mental health, and SUD treatment with personal life skills training.

- **The Montana Chemical Dependency Center**: The only state-run substance use disorder treatment center administered by the state of Montana for individuals 18 and older. MCDC uses a holistic approach to engage patients in a medical model of care that is patient-centered and outcome-informed. The clinical programming uses a co-occurring approach that is evidenced based with a multi-theory foundation and the entire team utilizes strength-based treatment approaches and skills-based learning. Case management services begin within 72 hours of admission and continue through the patient's entire stay at MCDC. The clinical program has an established, consistent schedule that includes AA/NA/Al-anon, peer support, vocational rehabilitation services, spiritual services, behavioral health services, medical educational services, and recreation services offered to the patients.

Recovery Support Services

- **Certified Behavioral Health Peer Support (CBHPPS) Services**: These are provided to adults with a severe and disabling mental illness and/or a substance use disorder. The services include coaching to restore skills; self-advocacy support; crisis/relapse support; facilitating the use of community resources; and restoring and facilitating natural supports and socialization. These services are available statewide.

- **Drop-in Centers**: A best practice intervention strategy to ensure a safe place for individuals that fits their personal needs or preferences and are voluntary. This early intervention engages individuals in socialization, crisis mitigation, and overall quality of life improvement. There are currently seven peer-operated Drop-In Center providers in Montana.

- **Supported Employment Services**: These services help provide access to employment resources for individuals with a behavioral health disorder by connecting them to a team of trained individuals who can provide support services that result in employment or continued education.

- **Projects for Assistance in Transition from Homelessness (PATH)**: PATH helps to provide secure, safe, and stable housing to individuals with serious mental illness and who are homeless or at risk of homelessness. Through such services as housing services, job training, education services, SUD services, referral to support services, and case management, PATH links a vulnerable population to supportive services that helps improve individual and population health.

AMDD Organization

The AMDD has three Bureaus that work collaboratively to implement and oversee all behavioral health services under the behavioral health continuum (prevention, early intervention, treatment, and recovery support). See attached AMDD organizational chart.

- The Prevention Bureau is responsible for oversight and management of the SABG, MHBG, and discretionary grant funded programs under contract.

- The Treatment Bureau is responsible for development of all behavioral health treatment services and provider requirements for Medicaid and federal & state-funded reimbursement for fee-for-service clinical services.
- The Fiscal Operations Bureau is responsible for oversight of all federal and state fiscal operations.

The Prevention Bureau

In FY 2019-2021, AMDD continues to work implementing primary prevention strategies with the contractors below residing in each of the 5 Montana Health Planning Regions identified in Montana. Additionally, AMDD manages five task orders with five reservations throughout Montana.

Contractors
Each contractor provides support to the Prevention Specialists in the county/reservation associated in their region. This support includes human resource needs, supplies, equipment, office space, communication needs, travel expenses and any other resource needed to complete their work.

Montana Health Planning Regions

Northwest Region
A maximum number of Prevention Specialists assigned to each community are as follows: Flathead: (1.0), Lincoln: (.5), Mineral: (.5), Missoula: (1.0), Ravalli: (1.0), Sanders (.5)
Total: 4.50 FTE, 9,360 Allocated Units of Service

Southwest Region
A maximum number of Prevention Specialists assigned to each community are as follows: Beaverhead: (.5), Butte-Silver Bow: (.75), Deer Lodge: (.5), Gallatin: (1.0); Jefferson: (.5), Lewis & Clark: (1.0), Madison: (.5), Park: (.5), Powell: (.5)
Total: 5.75 FTE, 11,960 Allocated Units of Service

North Central Region
A maximum number of Prevention Specialists assigned to each community are as follows: Cascade: (1.0), Pondera: (.5), Toole: (.5)
Total: 2.0 FTE, 4,160 Allocated Units of Service

South Central Region
A maximum number of Prevention Specialists assigned to each community are as follows: Carbon: (.5), Fergus: (1.0), Stillwater: (.5), Yellowstone: (1.0),
Total: 3.0 FTE, 6,240 Allocated Units of Service

Eastern Region
A maximum number of Prevention Specialists assigned to each community are as follows: Custer: (.5), Dawson: (1.0), Fallon: (.5), Phillips: (.5), Richland: (1.0), Valley: (.75),
Total: 4.25 FTE, 8,840 Allocated Units of Service

Reservations

Ft Belknap
Each reservation includes available .75 FTE. Ft. Belknap budgeted for a .5 FTE Prevention Specialist assigned under the Substance Abuse Block Grant to their tribal community.

Ft. Peck
Each reservation includes available .75 FTE. Ft. Peck budgeted for a .5 FTE Prevention Specialist assigned under the Substance Abuse Block Grant to their tribal community.

Confederated Salish Kootenai (CSKT)
Each reservation includes available .75 FTE. CSKT budgeted for a .5 FTE Prevention Specialist assigned under the Substance Abuse Block Grant to their tribal community.

Rocky Boy
Each reservation includes available .75 FTE. Rocky Boy budgeted for a 1.0 FTE Prevention Specialist assigned under the Substance Abuse Block Grant to their tribal community.

Blackfeet
Each reservation includes available .75 FTE. Blackfeet budgeted for a .5 FTE Prevention Specialist assigned under the Substance Abuse Block Grant to their tribal community.

Reservations Total:
Total: 3.0 FTE, 6,240 Allocated Units of Service

Prevention Specialist
Each Prevention Specialist within each county/reservation deliver primary prevention efforts, which includes services prior to the onset of a disorder. These services intend to prevent or reduce the risk of developing a behavioral health problem including underage substance use, prescription drug misuse, and illicit drug use.

Each prevention specialist within each subcontracted county/reservation in each region must target specific populations that deserve focused efforts, including:

- Military, Veterans, and Families
- Women, Children, and Families
- Colleges and Universities
- Native Americans and Alaskan Natives
- LBGTQ

Regional Technical Assistance Leaders (RTALs)

In 2018, the Department recognized a need for more Technical Assistance oversight to community Prevention Specialists. To accomplish this, the Department contracted with Youth

Connections, a prevention agency in Helena, to employ 6 Regional Technical Assistance Leaders-one for each health planning region. In 2019, the Department added 1 Regional Technical Assistance Leader to work only with the tribes. The Tribal Technical Assistance Leader responsibilities include identifying and implementing culturally appropriate programming while advocating for and ensuring that Montana prevention efforts align with the culturally specific needs and voices of our tribal communities. The TTAL position takes the lead in supporting solutions that are effective for unique native populations and working closely with Tribal Health partners to ensure accurate navigation of grant invoicing and payment to approve, modify and ensure success of PFS and Block Grant budgets, contracts and resolutions. The TTAL is also responsible for other Tribal specific duties and conditions as identified and approved by DPHHS in collaboration with the Contractor.

7 Regional Technical Assistance Leaders, who are contracted under one contract, to provide the below mentioned assistance to 28 counties and 5 reservations:

> *"Oversight, training and technical assistance to community-based prevention specialists in the areas of program development, quality assurance and data tracking, prevention workforce development and cultural competence training, and program evaluation."*
>
> *"Technical Assistance (TA) provided will include training and support in aligning community-based prevention strategies to priorities outlined in the public health Community Health Assessments and other community-based needs assessments regarding substance misuse/abuse; enhance existing coalition cohesiveness within the community to identify and implement evidence-based strategies, policies and programs to address the prevention outcomes and indicators outlined under the Block Grant State RFP and in the county-level public health Community Health Assessment; training on media development, quality assurance and other areas as approved by the Department."*

- The Program goals and objectives for the Regional Technical Assistance Prevention award are (4):
    1. Maximize and target training and technical assistance resources by coordinating efforts across multiple sectors to recruit, retain, educate and train the prevention workforce.
    2. Increase the use of evidence-based programs and strategies that lead to measurable outcomes.
    3. Increase the reach of prevention training through the application and use of technology (online classes, self-paced courses and webinars).
    4. To assist the community-based prevention awarded contractors in meeting Prevention Outcomes and Indicators and Program and Reporting requirements.

- **Regional Technical Assistance Leaders will be required to engage in the following technical assistance activities to provide expertise on program development tasks.**

- Ensure community prevention specialists are engaged, coordinating and collaborating with the public health Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) to address substance use/misuse prevention needs.

- **Assist community prevention specialists with:**
  - Developing prevention plans using a department provided logic model approach. Prevention plans must be pre-approved by the RTAL and Department to ensure the community-based strategies and activities utilize science-based principles and align with the State Health Improvement Plan (SHIP)
  - Completing the media campaign notification and assist in compliance to the Social Media Policy requirements
  - Developing community prevention budgets
  - Integrate community prevention efforts by using both the Strategic Prevention Framework and Public Health Model to ensure collaboration. The goal is to have one functional prevention plan for a community that encompasses existing needs assessments
  - Building strong relationships with community leaders.
  - Identifying evidence-based programs and strategies that best align to address the community needs as well as align with available resources, working in collaboration with Department's Evidence-Based Workgroup
  - Assist prior to submission of required data to the Department, to ensure information is complete and accurate
  - Completing an annual community coalition evaluation and coalition member retention rates. RTAL will provide TA on implementing the annual evaluation, will review the collected data to ensure fidelity and response rate are met before submitting to the Department

- **Quality Assurance/Data Tracking System (required):**
  - Assist with fiscal monitoring and provide TA on best-fit prevention activities to spend down funds
  - Review monthly FEi WITS data entries for compliance with federal and Department reporting standards
  - Participate with the Department on Community-based Prevention Contractor's annual performance review
  - Review monthly submission of community prevention specialist workforce development training in FEI systems WITS. Monitor monthly hours and report any discrepancies to the community prevention specialist

- **Workforce training and TA (required)**

        - Coordinate and provide SAPST (32 hours), Logic Model web-based training, WITS training (Substance Abuse Prevention Skills Training)
        - Provide and develop an annual training schedule to be approved by the Department
        - Provide information on available training opportunities
        - Participate in Quarterly Prevention Skype meeting
        - Provide technical assistance in a variety of formats
        - Explore with the Department a credentialing process for prevention workforce

    - **Program Evaluation (required):**
        - Develop and implement an evaluation of training and TA services and submit a summary of progress to the Department annually.
        - Review prevention plan/logic models for each community prevention specialist to monitor the progress of measures. Work with Department and PS to revise prevention plans if measures are not being met

FY 2019-2020 RTAL Successes

In 2019 and 2020, RTALs worked diligently to meet the objectives noted above. They created processes to organize trainings, assess workforce development, provide effective communication with Prevention Specialists, and evaluations to understand successes and challenges to continually adapt with the needs of the Prevention Specialists and contractors.

They identified lead TAs for evidence-based programs, policies, and practices being implemented in many counties throughout Montana.

- Lead TA for Communities that Cares: Evidence Based Program identified throughout several Montana counties.
- Lead TA for CONNECT Montana Referral System: Project identified in prevention contracts and task orders under the Partnership for Success grant, which coincides with the Substance Abuse Prevention Block Grant.
- Lead TA for Evidence Based Working Group: Identifies level of effectiveness for Evidence Based Programs, Policies and Practices approved for implementation.
- Lead TA for IC&RC Certification.

IC&RC: Certification for Prevention Specialists, 2021-2022

The RTALs assist the Department with developing a process to allow Prevention Specialists to become certified with an IC&RC credentialing service. The State and RTALs are working together to define a certification process for the Prevention Specialists under the SABG contracts. Creating a certification process for this profession will not only help train and retain the workforce but will also bring primary substance use prevention to the forefront of behavioral health in Montana. In a recent Workforce Development Assessment conducted by Youth

Connections,75.6% of Prevention Specialists reported they would be interested in becoming certified. Additionally, it is imperative that this process is started sooner than later, as the federal government may start requiring states have a certification process for Prevention Specialists in order to receive substance use prevention dollars. To complete this process, Youth Connections hired an Independent Contractor to develop a certification process. This individual will ensure the process is developed from the beginning stage of applying to IC&RC on behalf of the agency who will be carrying the certification board, all the way to creating a plan to ensure the sustainability of the certification process.

Additionally, all Regional Technical Assistance Leaders and County-level Prevention Specialists collaboration around Dissemination of Information on a Statewide Campaign:

Parenting Montana

Provides easy to use parenting tools that grow social and emotional skills in children – skills that lead to healthy and successful lives and reductions in risky behaviors like underage drinking. The tools are appropriate for elementary, middle, and high school children.
The ParentingMontana.org Prevention Specialist's Guide is designed to help Prevention Specialists engage parents in their communities to use the ParentingMontana.org website and tools. Included are guidance and resources to work with schools, social service agencies, healthcare providers, law enforcement, and others to connect parents and those in a parenting role to the ParentingMontana.org website. Online training resources are also available to support Montana's prevention workforce. Prevention Specialists can login on the bottom to access information on media, resources, coalition education and support and access to resources. To access this guide, go to: https://parentingmontana.org

SABG Primary Prevention Expenditures: 2018-2019

The SABG report for 2020 includes primary prevention expenditures at $764,940 by the following Institute of Medicine IOM categories:

- Universal Direct: $234,231
- Universal Indirect: $499,930
- Selective: $6,402
- Indicated: $24,377

This amount of $764,940 includes further detail below, which is a list of expenses per CSAP strategy:

- Environmental $19,576
- Community Based Process $412,922
- Information Dissemination $196,503
- Alternatives: $92,677
- Identification and Referral $1,404
- Education $41,857

SABG funds include $1,388,369 for SABG Prevention, which covers the following activities:

- Information Systems: $135,708

- Infrastructure Support: $599,415
- Training and Education: $653,246

The total amount of SABG expenditures for Primary Prevention equals $2,153,309 and contains 31% of the Substance Abuse Block Grant Award.

States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities.

Behavioral Health Treatment System (Medicaid and other State and Federal Funded)

Montana Chemical Dependency Center (MCDC)

MCDC is administered by the Department of Public Health & Human Services within the Addictive & Mental Disorders Division and is the only state administered in-patient addictions, co-occurring addictions, and psychiatric disorders treatment facility, as previously noted.,

MCDC models its treatment methods from on-going research into the neurobiology of addiction and related treatment regimens that have transformed the delivery of service. Detoxification services are provided on a standalone basis; provided as needed to individuals who are entering treatment. Treatment is individualized with no defined number of days required or mandatory discharges. An average length of stay is 35 days for individuals. Significant to the evolution of treatment at MCDC is the recognition and implementation of integrated treatment for persons with co-occurring addiction and psychiatric disorders. As with other States co-occurring disorders are the expectation not the exception, 75% – 80% of patients suffer from co-occurring disorders. Medication in treatment is now a significant factor in stabilizing and treating individuals with co-occurring disorders at MCDC allowing individuals to participate in their treatment more effectively. MCDC utilizes an interdisciplinary treatment team consisting of physicians, nurses, mental health therapists, addiction counselors and treatment aides. MCDC continues to develop treatment by implementing best practice models such as dialectical behavioral therapy, parenting, and trauma related services.

Referrals into MCDC come from the entire state of Montana from community and reservation-based programs. Individuals must be referred by a Montana Licensed Addiction Counselor (LAC) and meet the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for this level of care which is in-patient medically monitored treatment. MCDC serves both male and female adult (18 years of age or older) patients in a non-secure, 24-hour, seven day a week, residential environment. This facility serves approximately 600 patients per year.

MCDC is dually licensed by the State of Montana as a chemical dependency treatment facility as well as a health care facility. MCDC is a 3-building facility with 16 beds for men at the clinically managed high intensity (ASAM 3.5) level of care, 16 beds for women at the clinically managed high intensity (ASAM 3.5) level of care and 16 beds for those individuals needing medically monitored inpatient (ASAM 3.7) level of care. Funding for the facility is appropriated

by the state legislature with funding being from state special revenue alcohol tax, Medicaid, and federal block grant with a current annual budget of $ 4.5 million.

Community Inpatient, Residential, and Outpatient Substance Use Disorder Treatment

The Montana Code Annotated (MCA) - Montana Law - establishes the ability for the Department of Public Health and Human Services to establish substance use disorder prevention and treatment systems within the state through a develop "State Approved" provider system. A "State Approval" is equated to a license for a facility providing substance use disorders treatment. Within MCA, the Department must consider duplication and need of services in the authorization of a facility for "State Approval".

- Attached is a map of state-approved providers throughout Montana. A more detailed breakdown of services and providers is available at https://mtdphhs.maps.arcgis.com/apps/MapSeries/index.html?appid=0a11b778701648a2a540d8762bd03fde.
- Each provider is required to maintain a State Approval Status for each treatment modality offered in their facility in order to access Block Grant Funding.
    - Steps on how to obtain a state-approval are attached.
- As part of the contracting process, providers are required to focus efforts on the critical populations identified by the Code of Federal Regulations in the following order:

    - Pregnant injecting drug users
    - Pregnant substance abusers
    - Other injecting drug users
    - Individuals infected or testing positive for Tuberculosis and those with the etiologic agent for Acquired Immune Deficiency Syndrome
    - Women with Dependent Children
    - Aged and homeless
    - Criminal Justice
    - All other individuals seeking services

- Each provider is required to implement evidence-based practices to address their identified needs of people in treatment services. This includes providing culturally competent services to those identified populations.
- Each provider is required to provide a mental health screening to all individuals in services and either provide needed co-occurring services (if licensed to do so) or to have partnership agreements with mental health centers for services.
- Almost all providers are privately owned (one is operated by county government).
- All providers are required to enroll into the Medicaid program as part of the contracting process.
- 46 of the 56 counties are considered frontier counties.

Co-Occurring Disorders

Community providers for both mental health and/or substance abuse services shall provide a safe and welcoming environment. This will assure that any individual seeking services will feel

accepted and respected no matter the reason for which they are seeking help. The physical, technological, and professional environment should be sensitive to issues of compromised capacity, gender, ethnicity, and multiple needs.

Community providers must adopt specific policies and practices that engage all potential clients into services. The Division policy is that all clients can be helped through timely assessment, collaboration, and active referral.

All individuals presenting for services in any program will receive integrated screening to identify the presence of possible co-occurring disorders. Each program develops procedures that define how this screening will be conducted for all new client's entering either a mental health or substance related facility so that there is "no wrong door" to treatment access.

Over six percent (6.6%) of Montana's tax on the sales of alcohol is earmarked for the treatment of co-occurring disorders. This money provides mental health services within the addiction service system for those individuals with co-occurring disorders that are not covered by other indigent funding sources. Programs providing these services either have staff available with appropriate services or purchase these services through referral.

In 2018, AMDD amended reimbursement methodologies for SUD assessment, individual therapy, and group therapy from the Healthcare Common Procedure Coding System (HCPC) to the national standard Current Procedural Terminology (CPT) codes. The change from HCPC codes to CPT codes aligned service requirements and reimbursement methodology for substance use disorder treatment providers with other behavioral health professionals, including mental health professionals.

Further alignment took place in 2018, when AMDD created the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health. The manual provides services definitions, provider requirements, and services requirements for both SUD and adult mental health Medicaid funded services in one location. General requirements have been normalized between SUD and adult mental health and include assessments and individualized treatment planning. This sets the foundation to support co-occurring services.

In 2019, AMDD created tiered bundled rates for Intensive Outpatient (IOP) Therapy for SUD treatment to support access to IOP, which included an add on enhancement for co-occurring mental health treatment. In addition, in the 2019 Montana Legislative session, funding was provided for mental health certified peer support services as part of Montana's Medicaid service array. AMDD chose to also fund certified peer support services for SUD and submitted a state plan amendment to add Certified Behavioral Health Peer Support for both SUD and adult mental health to the Medicaid service array. Co-occurring Certified Behavioral Health Peer Support services will be monitored moving forward.

Through its Prevention and Treatment Bureaus, AMDD assesses the need for mental health and substance use disorder treatment and prevention services throughout Montana. Because Montana is a frontier state, the AMDD continues to face challenges in delivering SUD and adult mental health services to all areas. To counter these challenges, multiple departments and organizations have been working to increase access and available services state-wide, especially in rural communities. Many licensed Mental Health Centers have satellite offices in rural areas around the state. Montana also has Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs), as

well as Federally Qualified Health Center (FQHC) sites located outside of urbanized areas providing emergency/crisis care, primary care, behavioral health services, dental care, etc. Attached is a map provided by the Rural Health Information Hub that represents the location of these entities outside of the urban areas within the state (https://www.ruralhealthinfo.org/resources/5284).

MT's community-based mental health services are provided by a variety of local agencies including licensed Mental Health Centers, independent private practitioners, Federally Qualified Health Centers (FQHC), and short-term psychiatric inpatient units in community hospitals. The psychiatric inpatient units are in Kalispell, Missoula, Billings, Helena, Glendive, and Great Falls. MT currently has 15 licensed Mental Health Centers that can provide community-based services in 55 of 56 counties, with the use of 60 satellite offices, and approximately 24,573 individuals determined eligible for Medicaid or State supported mental health services. Mental Health Center locations may be reviewed on the attached Mental Health Centers list.

Substance abuse disorder treatment services are provided through contracted State Approved Programs at the following Level of services:

- Assessment/Course/Treatment (DUI)
- MIP Classes
- Outpatient/IOP Services
- Co-occurring Services
- Recovery Homes
- Women's & Children's Homes
- Day Treatment (adolescent)
- Community Based Inpatient Res. (adolescent)
- Community Based Inpatient Res. (adult)
- Inpatient Free Standing (adult)
- Federally Qualified Health Centers
- Tribal (Reservation) Agencies
- Tribal (Urban) Agencies
- Hospitals

Most state approved agencies have integrated into mental health agencies; employ a full continuum of mental health staff to provide services; or contract or have agreements with mental health services to be performed by the appropriate licensed mental health personnel. These state approved agencies provide some level of integrated behavioral services for both youth and adults (birth to death). MT's current SUD treatment capacity within this system is approximately 7,000 people a year.

Each state approved provider is required to implement evidence-based practices to address their identified needs of people in treatment services. This includes providing culturally competent services to those identified populations.

- Each provider is required to provide a mental health screening to all individuals in services and either provide needed co-occurring services (if licensed to do so) or to have partnership agreements with mental health centers for services.
- Almost all providers are privately owned (one is operated by county government).
- All providers are required to enroll into the Medicaid program as part of the contracting process

Resources for Behavioral Health Treatment

Recovery-Oriented Cognitive Therapy (CT-R)

In 2017, Montana was one of six states to win a Transformation Technology Initiative grant from the National Association of Mental Health Program Directors to introduce recovery-oriented cognitive therapy (CT-R) into mental health services in the state of Montana. The primary aims of the training were to enhance the skill set of Montana State Hospital (MSH) and community staff at various levels of training and experience, improve outcomes of individuals with serious mental illness, while additionally promoting and improving continuity of care, breaking the cycle of discharges and recommitments to MSH.

MSH collaboration was multisector and included hospital leadership in addition to community mental health centers who provide Program of Assertive Community Treatment (PACT), three Projects for Assistance in Transition from Homelessness (PATH) teams, two Intensive Community-Based Rehabilitation (ICBR) group home providers, Montana chapter of the National Alliance on Mental Illness (NAMI) and Montana Peer Network and Recovery Coaches/Peer Support Specialist.

Montana contracted with the Aaron Beck Center with the University of Pennsylvania to provide both CT-R workshops as well as Train-the-Trainer workshops to staff at MSH and select community providers. This training was so well received that Montana expanded the contract with the Aaron Beck Center to provide three additional workshops and Train-the-Trainer workshops in Missoula, Bozeman, and Billings.

Crisis Intervention Team Program

Montana funded the development of Crisis Intervention Team programs across the state to increase communication between law enforcement and mental health professional and to provide ongoing education and professional development to the CIT programs.

- Support and expand community crisis systems and CIT training across the state of Montana
- Increase the skill level of law enforcement professionals when responding to persons with mental disorders who may encounter the criminal justice system
- Increase communication between mental health professionals and law enforcement
- Provide mentoring and technical assistance to emerging CIT programs
- Facilitate team attendance at professional development training opportunities including the CIT International Conference
- Collect and report on data relative to CIT program development to include number of officers trained, locations of established CIT programs, and impacts of the program

Integration of Peer Support within a Clinical System

In the 2019 Montana Legislative Session, Montana approved adding Peer Support Services to the Medicaid state plan for reimbursement for Montana Medicaid members who have a Severe and

Disabling Mental Illness (SDMI). Montana has provided training on the integration of peer support services within clinical operations. Senior leadership of organizations who provide BHPS services or are interested in providing BHPS services were invited to attend this training to learn, share, and discuss the role of a dedicated peer and the value they play in service delivery in September of 2019.

Peer Support Services are provided by a Certified Peer Support Specialist to promote empowerment, self-determination, and positive coping skills through mentoring and other activities that assist a person with severe disabling mental illness to achieve their goals for personal wellness and recovery. Peer Support Specialists have lived experience with mental illness and mental health services, are self-identified and well-grounded in their recovery process, and have completed a Peer Certification Course approved by the Department. They work under the direction of an approved Medicaid HCBS provider agency. The services are coordinated within the context of a comprehensive, Person-Centered Recovery Plan that includes specific individualized goals and delineates activities intended to achieve the identified goals.

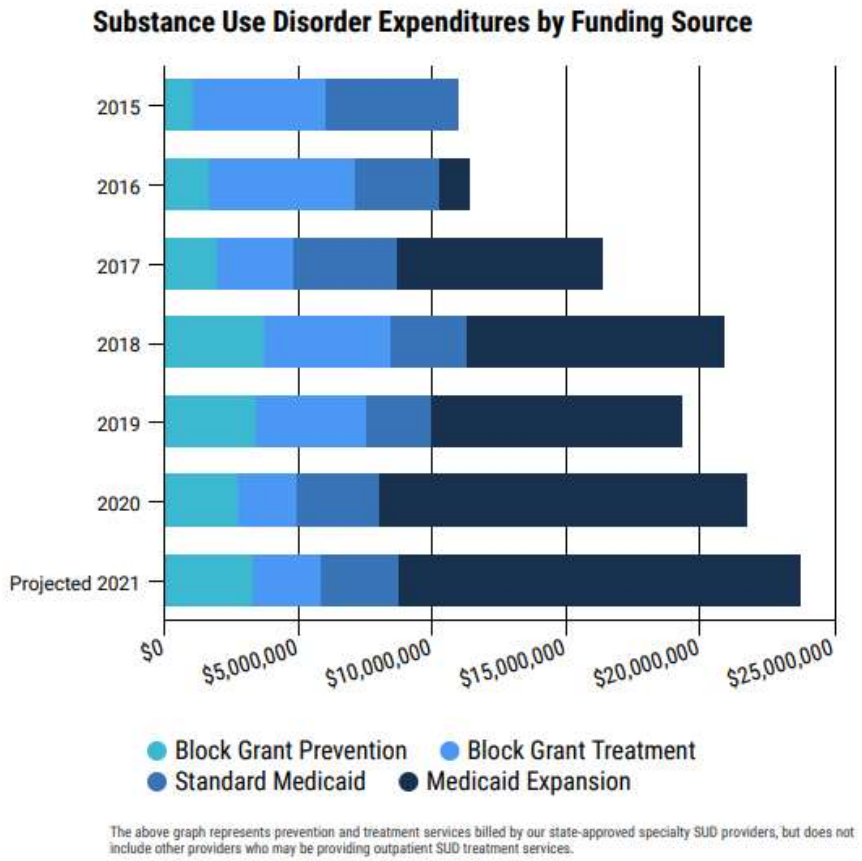
Peer Support Specialist Requirements:

- Must complete a minimum of 30 hours of peer support training
- The peer support training curriculum must be approved by the Department. Certified Peer Support Specialists are required to have 10 hours of continuing education annually.
- Core Competencies of the peer support specialist include, but are not limited to:
    - Effective use of lived experience to support an individual's recovery journey
    - Listening skills and cultural competence
    - HIPAA, Confidentiality, and mandatory reporting
    - Effective written and verbal communication skills
    - Mentoring individuals who are in recovery
    - Planning for crises prevention and recovery, including assistance with WRAP plans
    - Development and use of natural supports
    - Advocacy across and within systems (education, health, public benefits, behavioral health, etc.)
    - Documentation, evaluation, and achieving outcomes
    - Knowledge and practice of ethical boundaries
    - Strong networking skills

Financial Resources and Staffing

Medicaid Expansion

The Fiscal Operations Bureau within AMDD manages all fiscal operations and reimbursement for publicly funded (State and Federal) adult mental health and substance use disorder treatment for all ages. Funding for SUD treatment and prevention comes from a variety of sources, as can be seen in the following graph. As can be seen in this same graph, Montana has implemented Medicaid expansion that has been growing since its implementation.

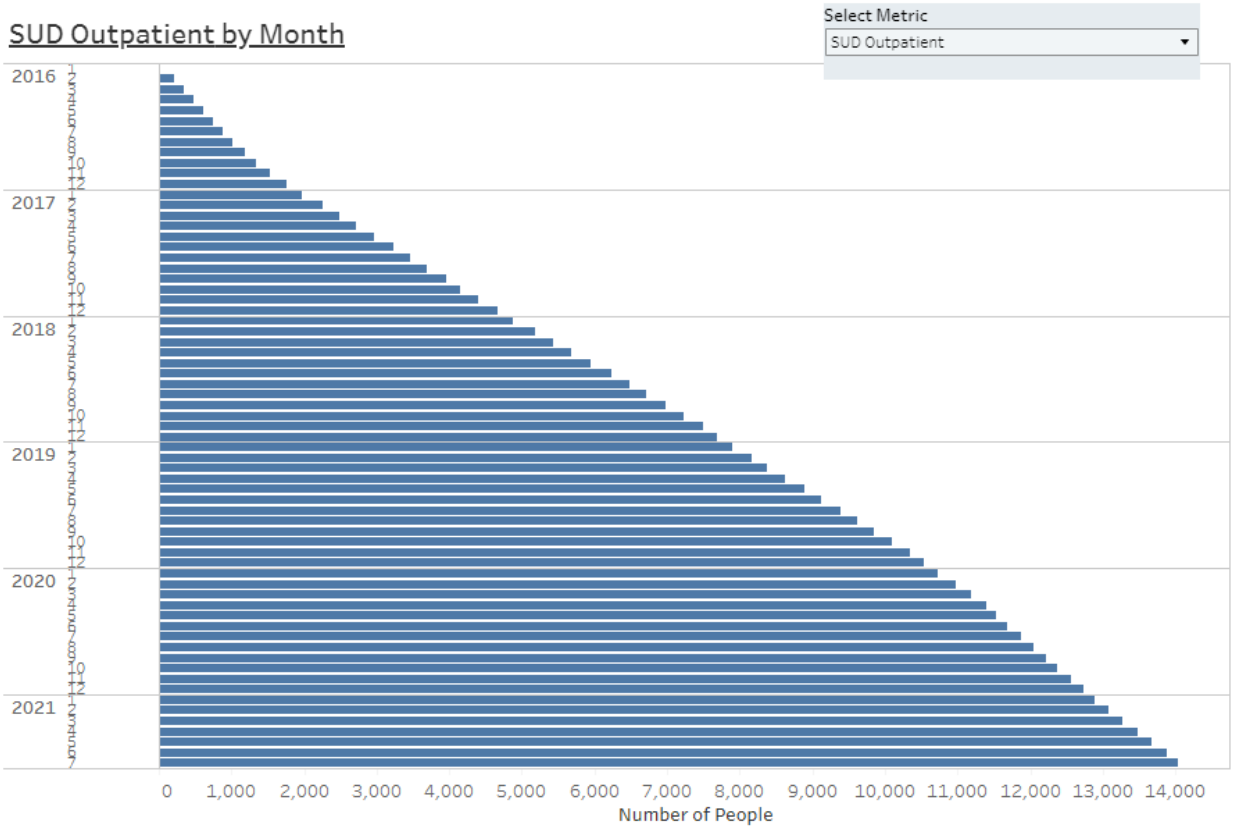


Thanks to Medicaid expansion, Montana has been able to cultivate a continuum of care for treating mental illness and SUD. This is partly because this expansion has allowed the state to use more SABG funds for prevention and recovery services while allocating Medicaid funds to treatment and intervention. As a result of the Medicaid expansion:

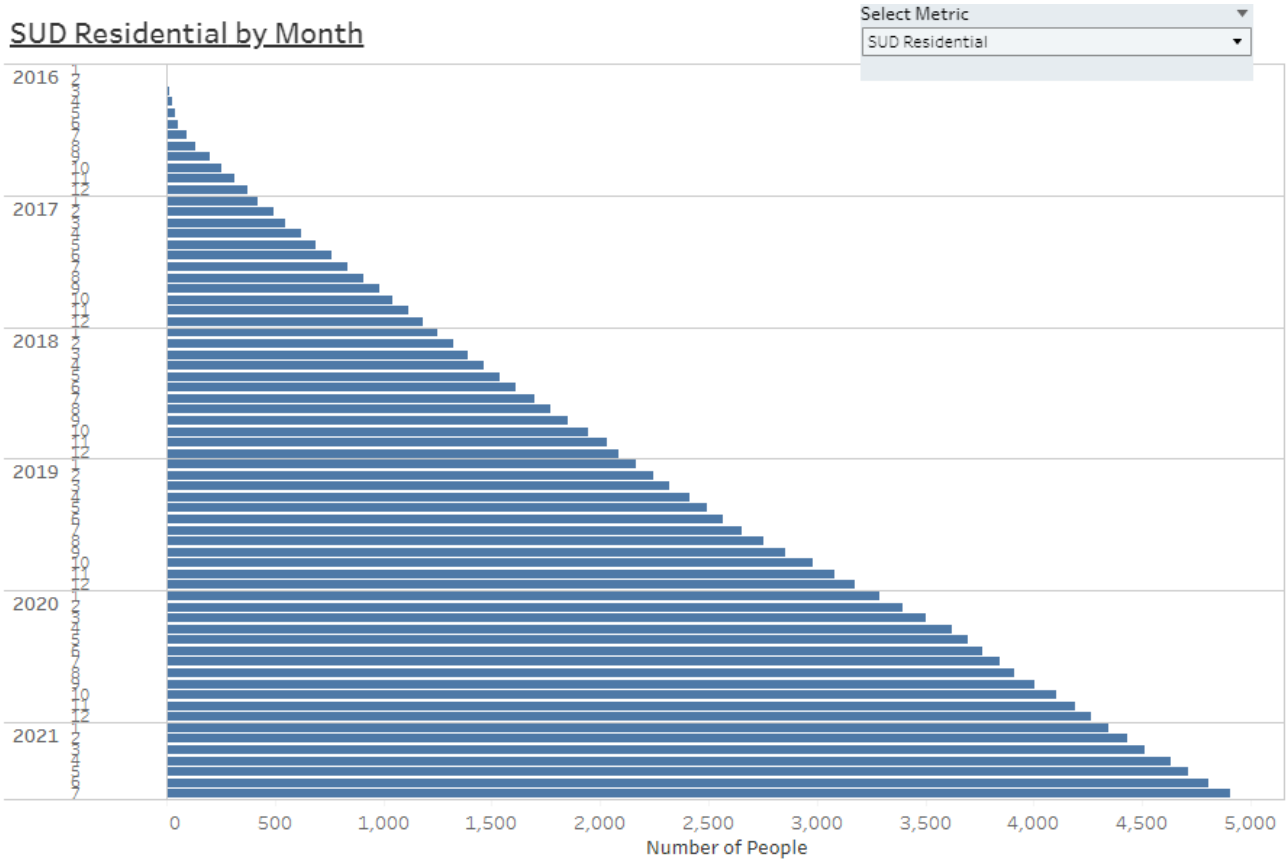
- 62,556 adult Medicaid members received mental health services
    - 35% were served through traditional Medicaid
    - 65% were served through Medicaid expansion
- 37,390 Medicaid members received substance use disorder (SUD) services
    - 21% were served through traditional Medicaid
    - 79% were served through Medicaid expansion
- Montana saw a 30% increase in Medicaid expenditures between 2015 and 2019
    - In FY2015, Medicaid behavioral health services were reimbursed in the amount of $68,798,665
    - In FY2019, Medicaid behavioral health services were reimbursed in the amount of $100,573,163
        - $53,331,168 was reimbursed through traditional Medicaid
        - $47,241,995 was reimbursed through Medicaid expansion

Without question, the expansion of Medicaid has allowed for a significant number of Montanans that were previously unqualified to receive state financial help to seek and receive treatment for mental and substance use disorders. Below are indicators of the impact this expansion has had specifically on SUD treatment since its adoption in 2016 (Medicaid Expansion Dashboard (mt.gov)).

SUD Outpatient by Month



SUD Residential by Month



HEART Initiative

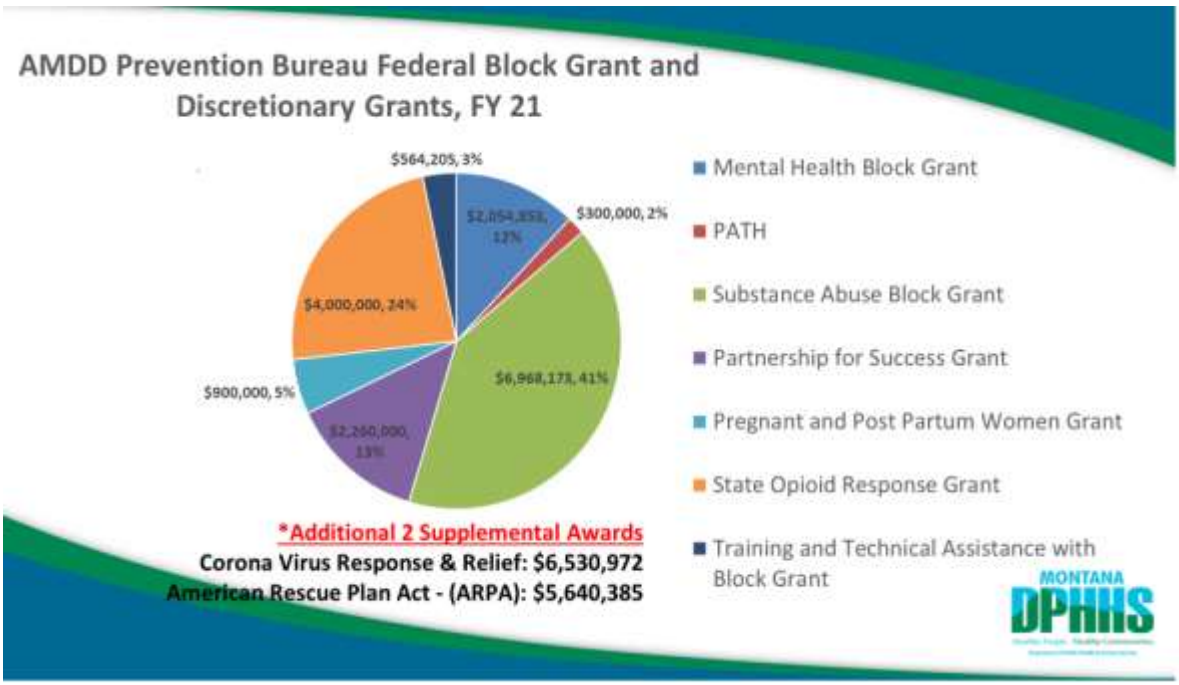
Montana Governor Greg Gianforte has introduced an initiative to build upon the accomplishments the state has achieved in creating a comprehensive continuum of behavioral health care. It is titled the Healing and Ending Addiction through Recovery and Treatment (HEART) Initiative. This will invest significant state and federal funding to expand the behavioral health continuum. The initiative will support the state's broader efforts to strengthen its evidence-based behavioral health continuum of care for individuals with SUD, SMI, and SED; enable prevention and earlier identification of behavioral health needs across outpatient, residential, and inpatient settings through improved data collection and reporting.
Montana is seeking through this demonstration

- To add new Medicaid services including
    - Evidence-based stimulant use disorder treatment models, including contingency management
    - Tenancy support
    - Pre-release care management and limited Medicaid services to be provided to inmates in the 30 days pre-release
- Expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of institutes for mental disease (IMDs) obtaining treatment for SUD and SMI

All children ages 18-20 years old and adults eligible to receive full Medicaid benefits under the Montana State Plan, Alternative Benefit Plan, or Medicaid 1115 waivers, as well as children aged 18 eligible for the CHIP program, will be included in this initiative. Medicaid members will qualify for services based upon their medical needs for services. Medicaid member eligibility requirements will not differ from the approved Medicaid State Plan, Alternative Benefit Plan, and Medicaid 1115 waivers.

FY 21 Grant Funding

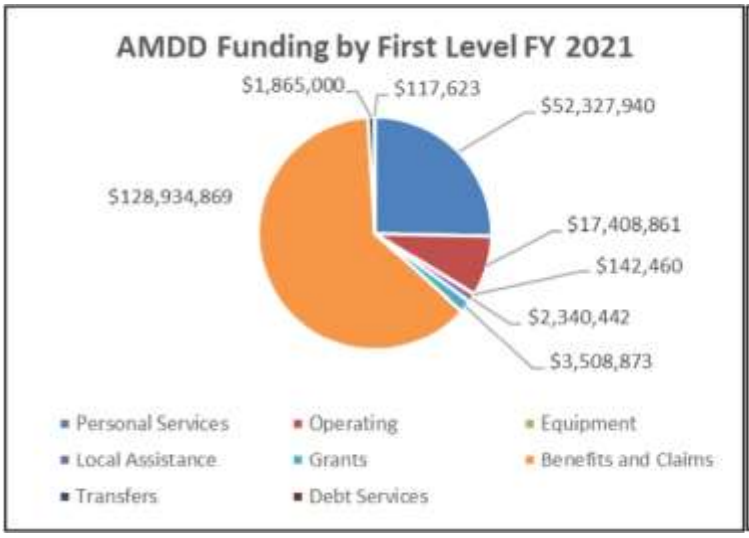
Below is a chart detailing the federal block grants and discretionary grants the Prevention Bureau of AMDD received during fiscal year 2021 that have allowed the state to improve prevention programs and initiatives throughout the state.

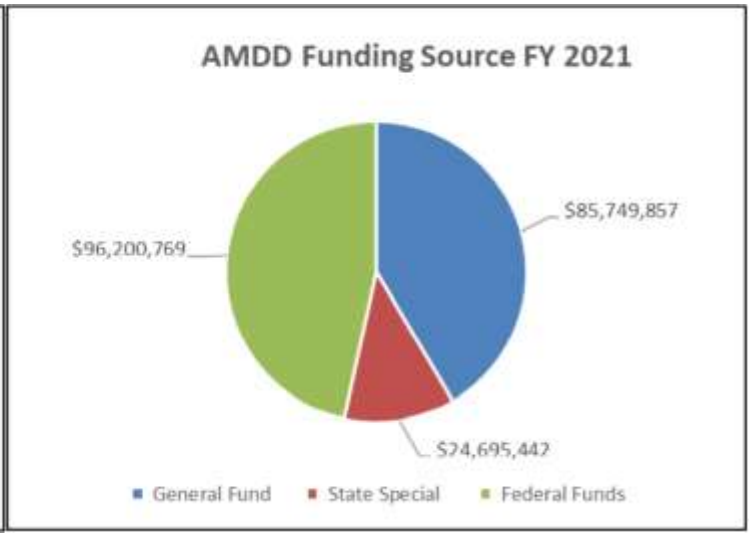

AMDD Prevention Bureau Federal Block Grant and Discretionary Grants, FY 21
$564,205, 3%
$300,000, 2%
$4,000,000, 24%
$900,000, 5%
$6,968,173, 41%
Mental Health Block Grant
PATH
Substance Abuse Block Grant
Partnership for Success Grant
Pregnant and Post Partum Women Grant
State Opioid Response Grant
Training and Technical Assistance with Block Grant
*Additional 2 Supplemental Awards
Corona Virus Response & Relief: $6,530,972
American Rescue Plan Act - (ARPA): $5,640,385
MONTANA DPHHS

Funding and FTE Information

Addictive and Mental Disorders	FY 2021 Budget	FY 2022 Request	FY 2023 Request
FTE	741.75	742.75	742.75
Personal Services	$52,327,940	$52,885,935	$54,335,312
Operating Expenses	$17,408,861	$18,163,114	$18,167,644
Equipment	$142,460	$142,460	$142,460
Local Assistance	$2,340,442	$2,340,442	$2,340,442
Grants	$3,508,873	$3,598,873	$3,598,873
Benefits & Claims	$128,934,869	$186,454,591	$194,426,332
Transfers	$1,865,000	$1,865,000	$1,865,000
Debt Service	$117,623	$115,146	$80,387
TOTAL COSTS	$206,646,068	$267,565,561	$276,956,450

	FY 2021 Budget	FY 2022 Request	FY 2023 Request
General Fund	$85,749,857	$89,198,151	$91,650,076
State Special	$24,695,442	$35,553,223	$36,680,118
Federal Funds	$96,200,769	$142,814,187	$148,626,256
TOTAL FUNDS	$206,646,068	$267,565,561	$276,956,450


AMDD Funding by First Level FY 2021
$1,865,000
$117,623
$52,327,940
$128,934,869
$17,408,861
$142,460
$2,340,442
$3,508,873
Personal Services
Operating
Equipment
Local Assistance
Grants
Benefits and Claims
Transfers
Debt Services


AMDD Funding Source FY 2021
$85,749,857
$96,200,769
$74,695,442
General Fund
State Special
Federal Funds

Behavioral Health Priorities and Target Populations

In collaboration with partners across the state, AMDD works to identify and address the critical need for providing care to transitional age youth, adults including older adults, families involved with protective services, and other disparate populations within Medicaid by improving the infrastructure for and access to the continuum of care, specifically treatment and recovery services.

Health Disparities

Good health begins at home, school, work, neighborhoods, and communities. The social and physical environment affects the way people live and their risk of illness or premature death. Key social determinants of health affecting the health of Montana residents include education, employment status, median income, housing, and adverse childhood experiences (ACEs). Childhood experiences, both positive and negative, have a tremendous impact on health throughout life. The following table shows social determinants of health among Montanans and U.S residents.

Social Determinants of Health	U.S	Montana
Education		
Public High School Graduation Rate*	**86%**	**87%**
Employment		
% unemployed[a]	**5.90%**	**3.70%**
Poverty		
% children under 18 living in poverty[b]	**14.40%**	**19.90%**
Median household income[c]	**$68,703**	**$54,970**
Housing		
Average % income spent on housing for those with a mortgage[c]	**27.90%**	**31.20%**
Average % income spent on housing for renters[c]	**18.50%**	**17.70%**
Food Security		
% households that receive SNAP[d]	**17%**	**9%**
Adverse Childhood Experiences (ACES)		
% children with 2+ ACES[e]	**21.70%**	**26.10%**

*National Center for Education Statistics
[a]U.S Bureau of Labor Statistics
[b]Montana State Library
[c]United States Census Bureau
[d]U.S Department of Agriculture Food and Nutrition Service
[e]Child and Adolescent Health Measurement Initiative

Suicide and SUD

For nearly 40 years, Montana's suicide rate has been among the highest nationwide, consistently ranking within the top five (36). As of 2019, Montana ranks third in highest suicide rates in the nation. Additionally, suicide is the *number one* preventable death in the state and is the *number two* cause of death for people ages 10-44. Every year, there are around 220-230 suicides in Montana. Suicide in Montana (mt.gov)

Groups at especially high risk for suicide include

- American Indians/Alaska Natives
- Individuals bereaved by suicide
- Individuals in justice and child welfare settings
- Individuals with mental and/or substance use disorders
- LGBTQ+ individuals
- Members of the armed forces
- Veterans
- Older men

All these groups are present in the state of Montana. It is estimated that 5,000 Montanans 18 or older attempted suicide between 2018 and 2019, 12,000 made suicide plans, and 38,000 had serious thoughts of suicide in the same time frame.

As previously mentioned, individuals who suffer from a substance use disorder are at a higher risk for suicide. Between 2018 and 2019, an estimated 83,000 Montanans aged 12 years and older (7.7%) needed but did not receive treatment for substance use in the past year. An estimated 64,000 Montanans aged 12 years and older needed but did not receive treatment for alcohol use between 2018 and 2019; 27,000 Montanans 12 years and older needed but did not receive treatment for illicit drug use in that same time frame. In all, an estimated 87,000 Montanans ages 12 and up suffer from a substance use disorder. This represents about 8% of the population of Montana. An important statistic to mention is the prevalence of past-month binge alcohol use among youth ages 12-17: during 2017-2019 the annual prevalence of this in Montana was 45.7%. This is significantly higher than both the regional (36.3%) and national (35.4%) averages. 2018-2019 National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia) (samhsa.gov)

Additionally, individuals with a mental disorder are at a higher risk for suicide and substance abuse. In Montana, between 2018 and 2019, 171,000 adults reported having a mental illness and 43,000 reported that mental illness to be serious. During this same time, 65,000 Montana adults reported suffering from a major depressive episode. Yet only 144,000 individuals in Montana received mental health services. 2018-2019 National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia) (samhsa.gov)

As for Montana youth, around 10,000 individuals aged 12-17 (8.8%) reported having a serious mental illness during 2017-2019. Between 2016 and 2019, 13.8% of 12 to 17-year-olds reported suffering from a major depressive episode (MDE) but only 44.8% of those individuals received treatment for their mental disorder.
Behavioral Health Barometer: Montana, Volume 6 (samhsa.gov)

As the National Institute of Mental Health notes, about 50% of all people with a mental disorder will also experience an SUD at some point in their lives. The opposite is true as well—half of the individuals with an SUD will also experience a mental disorder. Because of this, SUD treatment and mental disorder treatment tend to go hand in hand and having resources available for both health issues is paramount to public health and safety. Montana has already seen success in both areas throughout the state.

In 2014, nearly 18,000 adolescents (aged 17 years and younger) in Montana were served in Montana's public mental health system. (38) Of those, 64% reported improved functioning as a result of the treatment they received. (38) Meanwhile, among adults who received mental health treatment in Montana's public mental health system in 2014, 62% reported functional improvements.

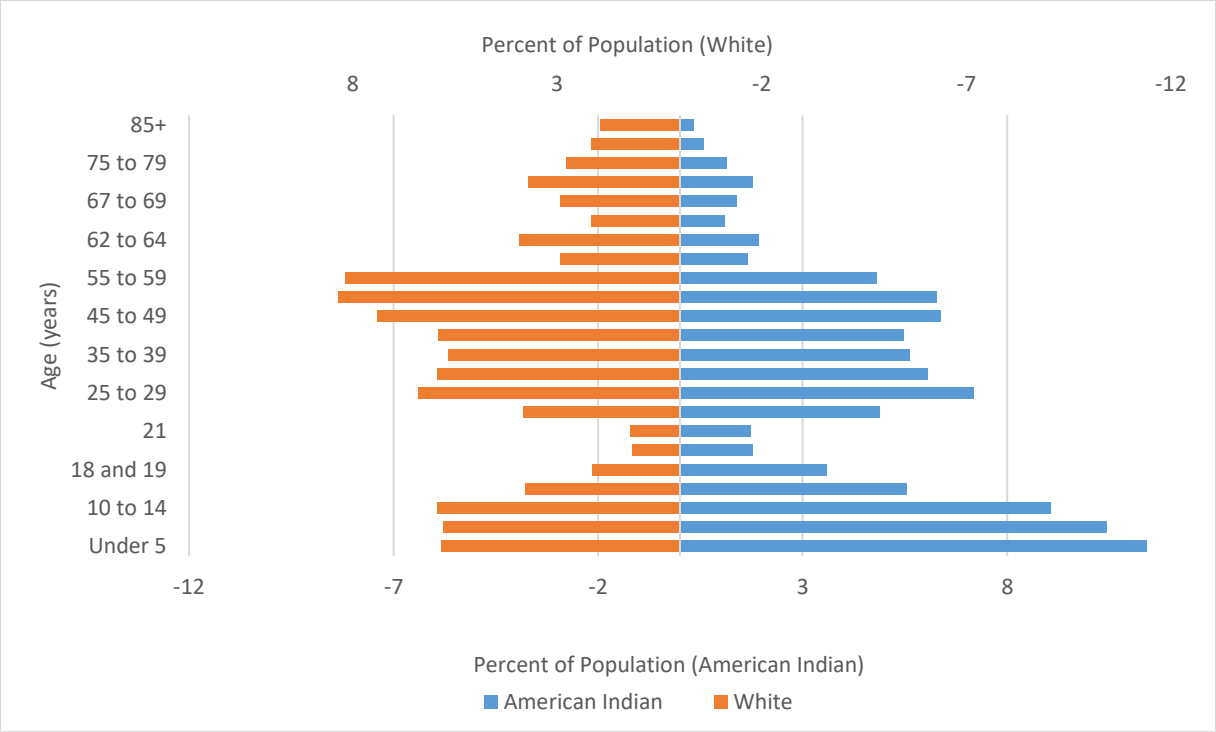
In state fiscal year 2016, over 24,000 adults with SDMI, co-occurring substance use disorders, and those experiencing a psychiatric crisis received services through publicly funded community-based behavioral services, an increase of nearly 48% since 2003. These programs included prevention and early intervention programs, crisis services, core mental health treatment, and transition and recovery services.

AMDD ensures behavioral health services are available to American Indians, Rural populations, Homelessness, Older Adults, Youth, and other disparate populations. Specifically:

American Indian

In 2019, Montana was home to an estimated 1,068,778 residents with 89% white and 7% American Indian. The American Indian population of Montana was younger than the white population (Figure 1). 21% of white residents were under age 18 years, compared to 36% of American Indian residents; and 16% of white residents were age 65 years or older, compared to 6% of American Indian residents.

Figure 1. Age-distribution among white and American Indian residents of Montana, 2019 and 2020
Data source: US Census Bureau



Efforts to include American Indian populations and communities within the behavioral health continuum are prioritized for all services provided under the continuum, funded through state and federal funds. Specifically:

- Task orders with MT tribes have been provided for SUD prevention programs.
- Task orders with selected MT tribes have been provided to implement Zero Suicide.
- Youth Native American Zero Suicide initiative being implemented within tribal reservations.
- Tribal Matching Grant funds available for crisis management funding.
- Medicaid expansion reauthorized that expands access to comprehensive physical and behavioral health care, with 100% match for tribal enrolled individuals.
- SABG funding to support non-Medicaid covered SUD treatment and recovery support services to tribes that are "State approved".

Rural Populations

The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

Because of the frontier nature of MT, our entire mental health service plan addresses the way mental health services will be provided to individuals residing in rural/frontier areas. Over 800 of the country's 3190 counties have been designated as frontier by the Frontier Education Center in consultation with State Offices of Rural Health. Most frontier land is in Alaska, the Great Plains, and the West. MT ranks number 3 out of 19 States that account for about 95 percent of the land

designated as frontier. By comparison, MT ranks 6th in Largest Frontier Population and, as noted above, third in Largest Frontier Area (National Center for Frontier Communities).

Concentrating services in larger areas may be the most efficient strategy for service delivery, however, MT has maintained an effort to provide individuals a choice of mental health services in every county in the State primarily through the Mental Health Centers and telemedicine. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, supportive therapy, and case management including TCM.

Homeless Populations

As of January 2020, around 1,500 people in Montana are homeless (US Interagency Council on Homelessness). Substance use and mental illness are strongly correlated with homelessness, therefore in order to fully address substance use and mental disorders, homelessness must also be addressed. The Projects for Assistance in Transition from Homelessness (PATH) programs supports SAMHSA's Strategic Initiates; specifically, Recovery Support. Three major Mental Health Centers concentrate service delivery in the areas of: outreach, in reach, screening and diagnostic treatment, community mental health, case management, referral for primary health services, job training, education, and relevant housing services. Enrolled individuals will all be provided the opportunity to transition to Mental Health Center services as soon as eligible and the MT PATH Program can ensure service stability for the individual. The MT PATH Program is critical to provide the outreach necessary for those experiencing severe and persistent mental illness and homelessness to access the mainstream public mental health system and accompanying community mental health services.

The SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative is part of the contractual requirements under PATH. As part of the SOAR Initiative, the State has designed and implemented a MT SOAR Strategic Plan (Attachment E, MT SOAR Strategic Plan). MT is using the SOAR Online Training to coordinate SOAR trainings statewide to Mental Health Center case managers and other organizations serving individuals who are homeless or at risk of homelessness. All PATH case managers/liaisons are required to complete the SOAR Online Training.

Housing services are an integral component of the PATH Program and critical to recovery for individuals with SMI and/or co-occurring disorder. The MT PATH Program works closely with the Department of Commerce in the areas of reporting for match requirements and housing grant opportunities.

Older Adults

Nationally, the State Health Insurance Assistance Program is a volunteer advocacy group whose primary mission is to educate and advocate for Medicare beneficiaries and their families. SHIP counselors frequently work with beneficiaries with varying levels and types of mental illness, as well as adults with disabilities. SHIP counselors are often in the position of assisting individuals whose independence rests, to some extent, on their ability to cope with everyday situations and challenges. The partnership with SHIP and AMDD is providing some basic mental health training and technical support to counselors. As the senior population grows, MT SHIP counselors report they are increasingly consulting with mentally ill beneficiaries, thus partnerships with AMDD are increasingly important.

Youth

Through the Mental Health and Substance Abuse block grants that AMDD receives, the department is able to help fund services throughout the state that directly impact Montana youth. These include School Based Services (SBS) and Parenting Education Classes. SBS are evidenced-based primary prevention/early intervention programs to prevent or reduce youth substance use. SBS are not therapy services, rather services designed to address problems or risk factors related to substance use consequences and are intended to promote protective factors and provide skills development. Throughout the period for the FY 20-21 Substance Abuse Block Grant, 10 out of the 32 providers that contracted with AMDD provided School-Based Services. Providers who opt to administer SBS must choose from one of the following evidence-based programs AND must be administered by staff who have gone through the training in the chosen model:

- LifeSkills Training®
- Project Towards No Drug Use®
- Team Intervene®
- State-wide Indian Drug Prevention Program®
- Prime for Life

In order to receive state funding for SBS, programs must submit a school-based service and evaluation plan for the current year to AMDD and collect and submit evaluation data monthly to the department.

Additionally, AMDD has recently begun offering funding for evidence-based primary prevention/early intervention programs that improve parenting skills for families involved with Child Family Services and SUD treatment programs. Said programs are called Parenting Education Classes. Similarly to SBS, these services are not therapy services, rather services designed to increase parenting skills and resources to enhance family unification and improve protective factors and life skills development. Positive American Indian Parenting is also offered and focuses on traditional and culturally specific parenting practices and values. For a program to be able to implement these classes, the services must be

- Evidence-based
- Culturally Responsive Instructional Resources for American Indians
- Pre-approved by the AMDD

Providers must submit an evidence-based or American Indian culturally responsive with an appropriate primary prevention/early intervention parenting education plan.

While parenting education classes are not directly offered to youth, their implementation throughout the state directly affects youth as parents have a lasting impact on their children and contribute significantly to their mental and physical well-being.

Juvenile Justice

- The Regional staff work as the liaisons to the Juvenile Justice system to ensure efforts are not only collaborative, but smooth when transitioning a youth in need of SED treatment from the Juvenile Justice system to a more appropriate setting.

- The SABG supports training to all state-approved treatment providers to get trained in Prime For Life and EBP education curriculum that specializes in youth prevention and risk reduction for alcohol, marijuana, and other substances. This course meets the administrative rule requirement for Minor In Possession (MIP) offenses.

Behavioral Health Partners and Stakeholders

AMDD Prevention Bureau provides evaluation and technical support to the local and regional planning groups, regional Service Area Authorities (SAA), and Local Advisory Councils (LAC). SAAs are statutorily defined, to collaboration, with the Department for the planning and oversight of mental health services within a service area. LACs are a coalition of individuals within communities interested in planning, evaluating, and strengthening their local community mental health services. All local planning groups are encouraged to ensure activities are conducted through a broad and inclusive representation of the community mental health system, including community mental health providers, advocates, law enforcement, judicial system, hospitals, and other medical service providers. LACs are the foundation for recommendations to the SAA, AMDD, and Behavioral Health Advisory Council (BHAC), formerly known as the Mental Health Oversight Advisory Council (MHOAC), on program issues affecting local communities. The AMDD Prevention Burau also facilitates and provides administrative functions for the BHAC.

Workforce Training

MT has incorporated strengths based and recovery-oriented services and training in their mental health system. Annually, the Governor's office provides training focusing on cultural diversity to help staff understand the barriers to health care.

Crisis Intervention Team Montana supports community-based behavioral health providers, law enforcement, first responders, and other local stakeholders training in the nationally recognized Crisis Intervention Team (CIT) model. The 40-hour training is held over the course of a week and includes courses on personality disorders, psychotropic medications and side effects, post-traumatic stress disorder, traumatic brain injury, suicide assessment, and youths' issues. The model facilitates a response system that is trauma-informed and seeks to utilize the most appropriate resources when an individual is experiencing a behavioral health crisis. In several Montana's communities, individuals calling 911 can request a CIT officer to respond to a behavioral health call.

The 2017 MT Legislature voted to not only continue, but to also expand funding for the AMDD County and Tribal Matching Grant program for CRI and Jail Diversion. Since 2009, a County Matching Grant program has been in place to address the critical need for crisis intervention and jail diversion in MT communities. To provide appropriate care for those in mental health crisis, many MT communities have no other option but to incarcerate or transport these individuals' long distances to the Montana State Hospital (MSH), the state's only public acute psychiatric hospital.

The lack of crisis intervention and jail diversion alternatives means communities must rely on the MSH for emergency and court ordered detention, and evaluation which increases costs for the community, strains the MSH, and diverts resources from community-based services. Per

Montana Code Annotated 53-21-1201, 53-21-1202, and 53-21-1203, the County and Tribal Matching Grant program funding consists of crisis intervention, jail diversion, insurance coverage against catastrophic pre-commitment costs if an insurance pool is established, and short-term inpatient treatment costs.

State matching funds granted to communities is a way to share costs and provide incentives for local resources to be spent on community-based treatment capacity rather than on jail capacity or on transportation to, and capacity in, the MSH. The program also encourages collaboration between local stakeholders, including law enforcement, hospitals, behavioral health providers, public health, and local leadership, to offer creative, sustainable solutions. The match funding was designated to be used to support new projects or enhance current ones. Examples of successful projects supported by matching grant funds in the past include development of crisis coalitions, development of new crisis stabilization facilities, and development of mobile crisis response teams.

Through House Bill 328, the 2019 Montana Legislature revised the statute to offer the matching grant fund opportunity to federally recognized Tribal Governments as well as extend the grant period from 1 year to 2, allowing additional time for counties and tribes to meet the community's project goals. A local investment county/tribal match is required for these funds. The match rate is determined based upon utilization rates at MSH.

SABG Priority and Performance Indicators:

FY19 Review:

Goal 1. The Addictive and Mental Disorders Division (AMDD) administers the Substance Abuse Prevention and Treatment Block Grant, a system of care designed for individuals who are not eligible for Medicaid or other funding sources and have a family income that does not exceed 200% of the Federal Poverty Level.

Objective: Provide individualized consumer driven substance abuse prevention and treatment services which are integrated with community based primary care and social systems to ensure continued recovery.

Indicator 1: Daily Living Assessment (DLA) to be collected on all clients receiving IOP services under Medicaid and Block Grant.

First Year Target: 1000 clients beginning 1/1/2020 to 12/31/2020.

Second Year Target: 1000 clients from 1/1/2021 to 12/31/2021.

Due to a change in the data collection process, Goal 1, First Year Target was not met. *

*Initial plans for data collection of this indicator fell through. A new Medicaid system was adopted to address this, so the data collection method has changed.

Goal 2. The misuse and abuse of alcohol, tobacco and other drugs is continuously evolving and changing. To ensure Montana is prepared to provide effective substance use disorder prevention and treatment service, AMDD is working to increase the number of providers and their knowledge, skills, and abilities to identify and prepare to provide prevention and treatment services to address emerging issues through expanded services, training/technical assistance, and programming.

Objective: Identify areas of unmet needs, gaps and emerging issues in the substance abuse and co-occurring continuum of care and work to meet needs, fill gaps and address emerging issues.

Indicator 2: Increase in the number of State Approved Substance Abuse Treatment Providers in geographically sparse areas.

First Year Target: By 12/31/20, increase the number of counties with at least one State Approved SUD Treatment Provider by 5% (2), for a total of 49 (88% of all counties).

Second Year Target: By 12/31/21, increase the number of counties with at least one State Approved SUD Treatment Provider by 5% (3), for a total of 52 (93% of all counties).

Goal 2, First Year Target was not met. The number of counties with state-approved providers did not increase or decrease. *

*In 2019 we had 47 counties with state approved providers. In 2020 we had 47 counties with state approved providers. While we increased the number of state approved providers by 8 additional programs in 2020 (60 at the end of 2019 and 68 at the end of 2020), the number of total counties with state approved programs did not change. Therefore, we did not meet an increase. (Data provided by Isaac Coy, Treatment Program Manager).

Goal 3: In order to efficiently and effectively use resources dedicated to the prevention and treatment of substance abuse, AMDD is focusing efforts and programming on the implementation of evidence-based practices to ensure appropriate patient placement and treatment; to make providing co-occurring and physical health care an expectation of substance abuse prevention and treatment services, not the exception; and to have a responsive and effective recovery-oriented system.

Objective: Reduce 30-day Alcohol use among youth in grades 8, 10, and 12 combined from 33.1% in 2017 to 26.1 % in 2024 Baseline 2017 YRBS

Indicator 3: All SABG Funded communities (35) implement a minimum of two local or regional policies that address youth alcohol targets by 2024.

First Year Target: 25% of communities (9) will have implemented at least 1 local or regional policy that addresses youth alcohol targets by 12/31/2020.

Second Year Target: 50% of communities (18) will have implemented at least 1 local or regional policy that addresses youth alcohol targets by 12/31/2021.

Goal 3, First Year Target was met. Second Year Target was also met. *

*Currently, 55% of all counties have implemented at least 1 local or regional policy that addresses youth alcohol targets.

FY21 Priorities and Indicators

Goal 1: To increase the number of Substance Abuse Disorder (SUD) Treatment Programs that access SAMHSA Block Grant funds to support pregnant women and women with dependent children and individuals who use IV drugs.

Objective: To support pregnant women and dependent children by utilizing block grant funds to financially assist their SUD Treatment Programs.

Indicator 1: Increase in the number of SUD Treatment Programs that access block grant funds to serve pregnant women and women with dependent children.

First Year Target: By the end of FY2022 we will increase the number of SUD Treatment Programs that access block grant funds to serve pregnant women and women with dependent children by 25%.

Second Year Target: By the end of FY2023, Montana will increase the number of SUD Treatment Programs that access block grant funds to serve pregnant women and women with dependent children and individual use of IV drugs by 25% of year 1 number.

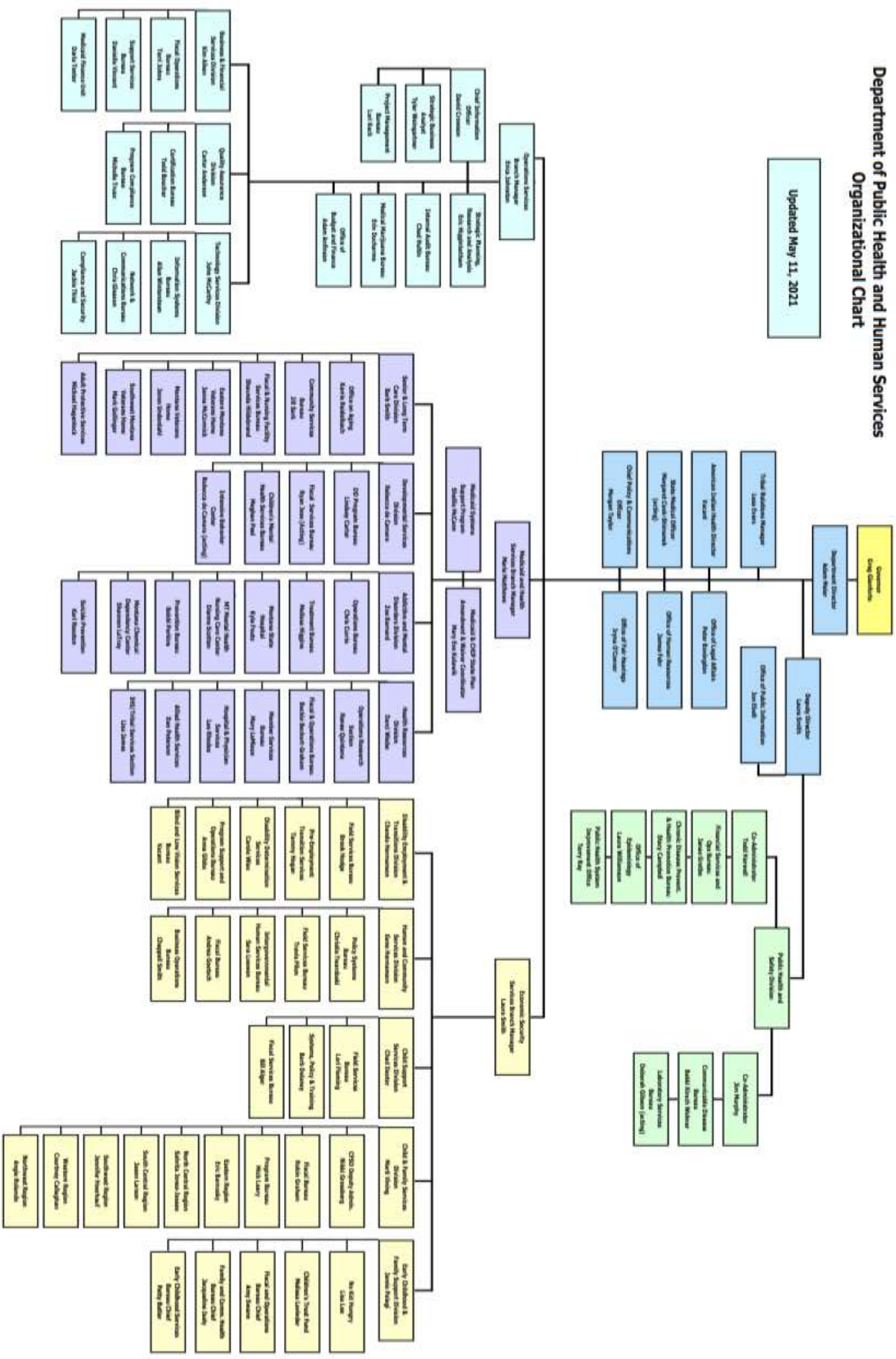
Goal 2: To expand recovery support services related to substance use by introducing or increasing an evidence-based program that is a peer group process by training facilitators in WRAP (Wellness Recovery Action Plan). "Training is Sustaining".

Objective: To support the training and implementation of WRAP facilitators and how this evidence-base program impacts individuals in recovery as a step-down process from a higher level of care.

Indicator 2: Increase in the number of trained WRAP facilitators in Montana.

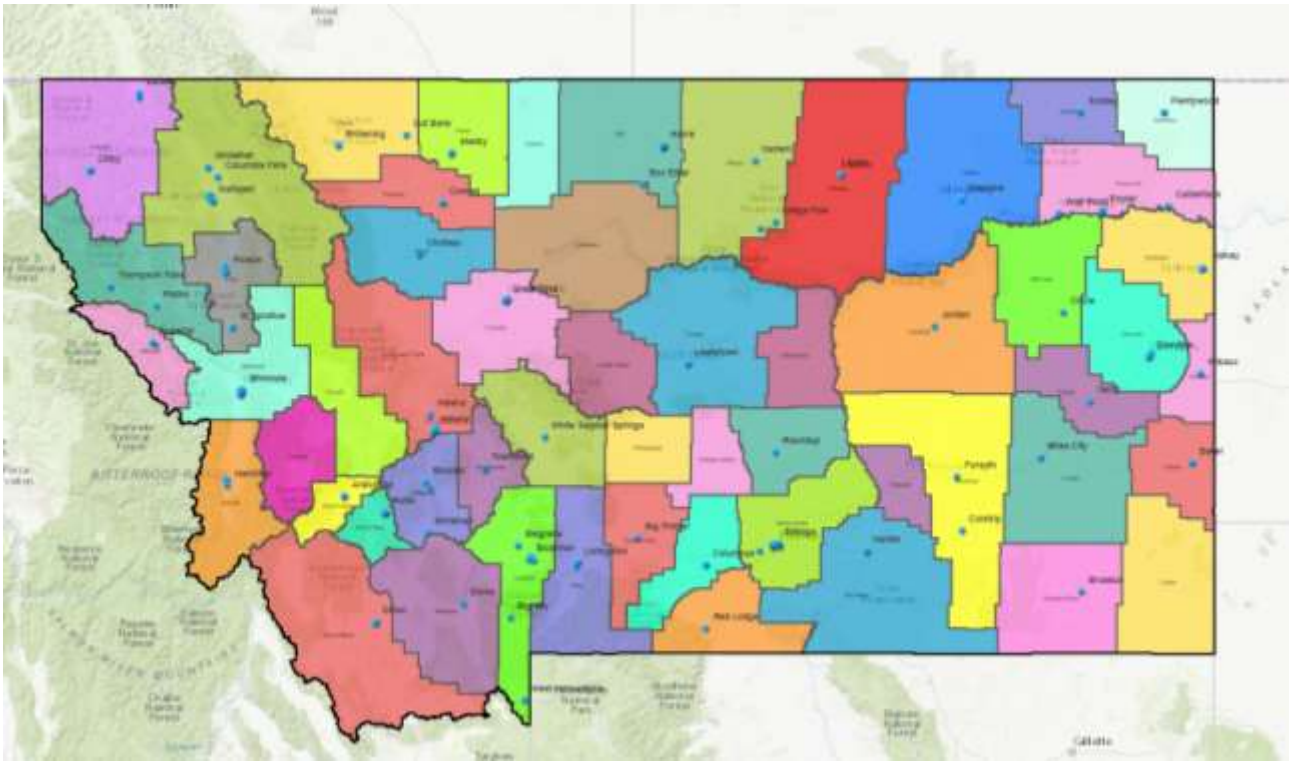
First Year Target: By the end of FY2022 Montana will increase the number of WRAP facilitators trained by 10%.

Second Year Target: By the end of FY2023, Montana will increase the number WRAP facilitators trained by 20%.

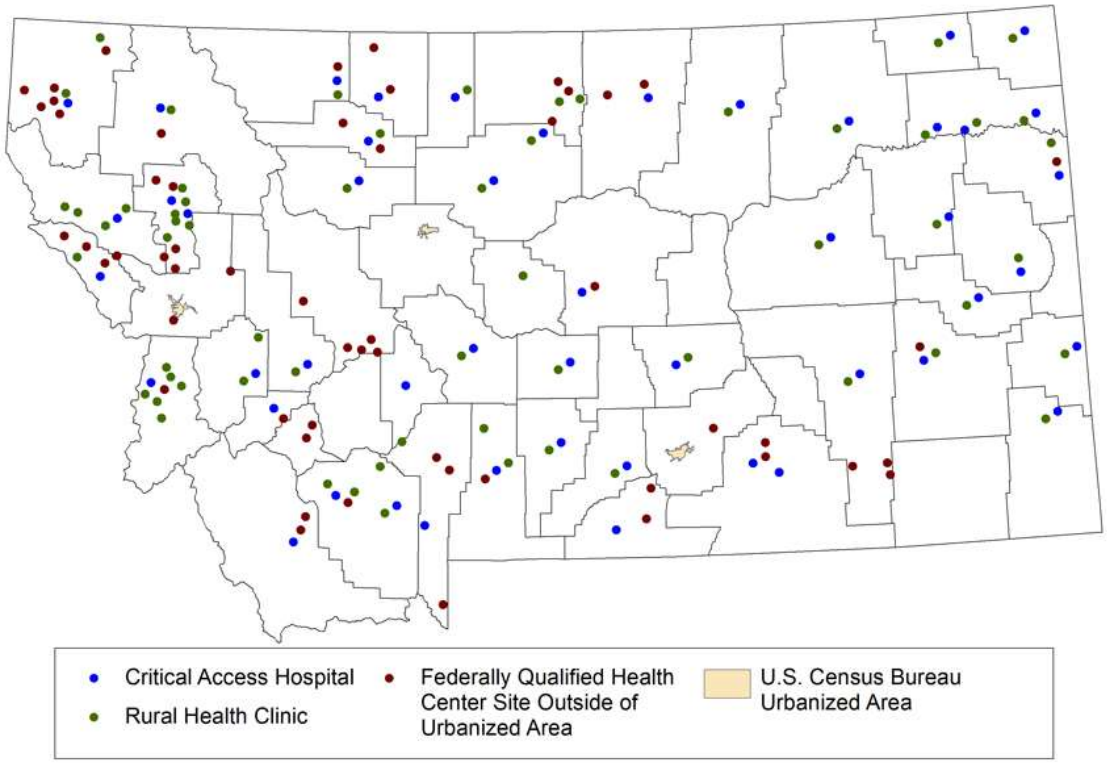

Department of Public Health and Human Services
Organizational Chart
Updated May 11, 2021

AMDD
Zoe Barnard
Administrator
31001
Shannon LaTray
Administrator
MCDC
Dianne Scotten
Administrator
MMHNCC
Kylie Foutz
Administrator
MSH
Jackie Jandt
Medicaid Reform
31735
Chris Currie
Bureau Chief
Operations Bureau
01220
Justin Harris
Contract Officer
00823
Rachel Hayes
Contracts Officer
41006
Christy Dighans
Budget Analyst
31030
Ronna Foster
Budget Analyst
31007
Jeff Conway
Grant \ Contracts Assistant
41015
Bobbi Perkins
Bureau Chief
41001
Karl Rosston
State Suicide
Prevention Coordinator
Madeline Boehm
Zero Suicide
37436
John Tabb
Suicide Prevention Program
Manager
Dana Geary
Block Grant Program Officer
32089
Curt Weiler
SAMS
31751
Rona McClimber
Data Analyst
31748
Jami Hansen
MHBG Program Manager
31013
Ki-Ai McBride
SOR Program Managent
31434
Penny Moon
Jocelynn Ware
STR/SOR Grant Manager
31742
Nikki Campbell
Pregnant Post Partum Specialist
37486
Kimberly Koch
Section Supervisor
31761
Gina Tracy
Prevention Program Manager
41008
Vacant
PFS Grant Manager 37435
Loeni Starcevich
FEMA Program Manager
37487
Melissa Higgins
Treatment Chief
Bureau Chief
07089
Helena Breidenbach
Mental Health Supervisor
Isaac Coy
Behavioral Health Supervisor
31010
Mary Collins
Special Populations
Supervisor
07041
Jennifer Fox
Program Manager
31702
Gwen Knight
QA Program Manager
31702
Kenny Bell
Community Program Officer
31704
Antonia Klein
Community Program Officer
31705
Vicky Varichak
Community Program Officer
31710
Rena Stayaert
Program Manager
31703
Cody Magpie
Program Manager (SUD)
41016
Barbara Canning-Grazlano
Program Manager (MH)
31745
Vacant
Behavioral Health Analyst
31030
Katie Rasmussen
Program Manager
41003
Vidot Bolstridge
Program Manager
41004
Wesley Wells
Program Manager.5 FTE
31760
Deborah Rumbergar
Medicaid Research
Analyst
31748
Miranda Griffis
Program Specialist
31722
Emily Burns
VISTA
Vacant
Mobile Crisis Program Manager
Cindy Dallas
Office Manager
32005
Yvonne Gentile
Administrative Assistant
41010
Revised 08-03-2021

Map of State-Approved SUD Treatment Providers in Montana



Selected Rural Healthcare Facilities in Montana



RHIhub
Rural Health Information Hub

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, January 2021

Mental Health Centers in Montana

Provider	Main Location	Satellite Locations	Services Provided
3 Rivers Mental Health Solutions	3214 Washburn Missoula, MT 59801	2031 Gaylord Butte, MT 59701	24/7 Crisis Response & Stabilization Chemical Dependency Referrals Day Treatment Foster Care Services Group Home Services Intensive Community Services Medication Management Outpatient Therapy Psychological Assessment Rehab and Support Supported Employment Targeted Case Management
AWARE	205 E Park St. Anaconda, MT 59711	616 Helena Ave. Helena, MT 59601 2300 Regent St. Suite 103 Missoula, MT 59801	Intensive Community Based Treatment (ICBR) Medication Management Outpatient Therapy Program for Assertive Community Treatment (PACT) Psychiatry/Tele-psychiatry Supported Living Targeted Case Management Youth Group Home Services

Center for Mental Health	Largent Building 915 1st Ave S Great Falls, MT 59403	214 S Main St. Boulder, MT 59632 236 Indiana Chinook, MT 59523 1 Main Ave. S Choteau, MT 59422 514 S Front St. Conrad, MT 59425 Courthouse Annex 1210 East Main Cut Bank, MT 59427 312 3rd St. Havre, MT 59501 900 N Jackson Helena, MT 59601 640 Park Ave. Shelby, MT 59474 515 Broadway Townsend, MT 59317	Adult Foster Care Services Adult Group Home Services Adult Therapeutic Aide Comprehensive School & Community Treatment (CSCT) Crisis Response and Stabilization Day Treatment Daily Living and Social Skills Domestic Violence Intervention Homeless Outreach Home Support Services Medication Management Outpatient Therapy Peer Support Program for Assertive Community Treatment (PACT) Substance Abuse Counseling Supported Employment Targeted Case Management Tele-Psychiatry Transitional Living Veteran's Services Youth Case Management Youth Therapeutic Group Home

Eastern Montana Community Mental Health Center	2508 Wilson Miles City, MT 59301	10 W Fallon Ave. Baker, MT 59313 507 S Lincoln Ave. Broadus, MT 59317 905 B Ave. Circle, MT 59215 415 Willow St. Colstrip, MT 59323 307 Broadway Culbertson, MT 59218 121 N 11th St. Forsyth, MT 59327 1009 Sixth Ave. N Glasgow, MT 59230 2016 N Merrill Glendive, MT 59330 46 S 1st St. E Malta, MT 59538 2508 Wilson St. Miles City, MT 59301 100 W Laurel Plentywood, MT 59254 301 East Blvd. Poplar, MT 59255 105 5th Ave. E Scobey, MT 59263	Outpatient therapy Medication Management Case Management Community-Based Psychiatric Recovery Services (CBPRS) Comprehensive School and Community Treatment (CSCT) Day Treatment Crisis Response and Stabilization · Recovery Home Chemical Dependency Services Prevention Services

		1201 W Holly Suite 4 Sidney, MT 59270 409 Bowen St. Terry, MT 59349 203 S Wilbaux Wilbaux, MT 59353 124 Custer St. Wolf Point, MT 59201	
Winds of Change	1120 Cedar St. Wolf Point, MT 59201		Outpatient Therapy Individual and Group Therapy – Youth and Adult Case Management Community-Based Psychiatric Recovery Services Peer Support Recovery Mall Adding SUD Treatment & ACT classes
L'Esprit Incorporated	Administrative Office: 111 N 3rd St. Livingston, MT 59047	120 S Main St. Livingston, MT 59047	Community-Based Psychiatric Recovery Services (CBPRS)Day Treatment Home Support Services Medication Management Outpatient Therapy (including individual, family, art, and group) Psychological Testing Targeted Case Management

Northern Winds Recovery Center	138 E Boundary St. Browning, MT 59417		Outpatient Therapy · Case Management Day Treatment Community-Based Psychiatric Recovery Services Psychological Testing
South Central Montana Regional Mental Health Center	Administrative Office: 2501 4th Ave. N Billings, MT 59101	1245 N 29th St. Billings, MT 59101 515 Hooper Big Timber, MT 59011 612 E Pike Columbus, MT 59019 809 N Custer Ave. Hardin, MT 59034 212 Wendall St. Lewistown, MT 59457 10 S Oakes Red Lodge, MT 59068 26 W Main St. Roundup, MT 59072	Outpatient Therapy Medication Management Program for Assertive Community Treatment (PACT)* Targeted Case Management (Lewistown only) Day Treatment* Project for Assistance in Transition from Homelessness* *not offered at all locations

Sunburst Foundation	109 First Ave. St. Ignatius, MT 59865	100 Dewey Ave. Eureka, MT 59917 2282 Hwy 93 S Kalispell, MT 59901 103 Whitewater Suite A Polson, MT 59860 108 E 9th St. Suite 11 Libby, MT 59923 1511 S Russell Missoula, MT 59802	Behavioral Intervention Drop-in Centers* Case Management Community-Based Psychiatric Recovery Services (CBPRS)* Medication Management Outpatient Services including: -Mental health individual, couples, and family therapy -Substance Use Disorder assessment and treatment* -Mental health and substance use group therapy *not offered at all locations
Montana Community Services	993 S 24th St. W Suite B Billings, MT 59102	100 Dewey Ave. Eureka, MT 59917 2282 Hwy 93 S Kalispell, MT 59901	Individual therapy Group therapy Family therapy
Mountain Home Montana	2606 S Ave. W Missoula, MT 59801		Individual therapy—Adult and Youth Group therapy—Adult and Youth 24/7 Crisis Line Children's therapy

Community Crisis Center	705 N 30th St. Billings, MT 59101		Crisis safety screening Stabilization plan development Chemical dependency evaluations Self-help groups Illness management and recovery Dual recovery Psychosocial assessments 24/7 Crisis line Case management
We Care Behavioral Health, LLC	2825 Stockyard Rd. Suite J6 Missoula, MT 59808		Adult Case Management Community-Based Rehabilitation Medication Management Outpatient Psychotherapy Services Peer Support Representative Payee Services
Montana State Hospital Mental Health Center	PO Box 300 Warm Springs, MT 59756		Group and Individual Adult Counseling Recreation Therapy Stabilization Co-Occurring Social and Independent Living Skills Adaptive Living Skills

Western Montana Mental Health Center	140 N Russell Missoula, MT 59801	1315 Wyoming St. Missoula, MT 59801 307 E Park St. Suite 211 Anaconda, MT 59711 Gallatin Mental Health Center 699 Farmhouse Ln. Bozeman, MT 59715 106 W Broadway St. Butte, MT 59701 Riverfront Mental Health Center 209 N 10th St. Suite A Hamilton, MT 59840 410 Windward Way Kalispell, MT 59901 Lake County Mental Health Center 8 2nd Ave. SW Ronan, MT 59864 602 Preston Ave. Thompson Falls, MT 59873 Dakota Place 1273 Dakota St. Missoula, MT 59801 Hay Morris House 24 E Copper St. Butte, MT 59701	Adult Group Home Services* Case Management Client Housing* Crisis Residential Services* Crisis Response and Stabilization* Day Treatment* Drop-in Center* Outpatient Therapy Program for Assertive Community Treatment (PACT)* Medication Management Mobile Community Treatment Medication Management Crisis Stabilization Program* Inpatient Co-occurring Treatment* Partial Hospitalization Treatment* Outpatient Medication Management* Outpatient IMAT Medication Management w/ group and individual therapy* *not offered at all locations

		Lake House 106 4th Ave. E Polson, MT 59860 Safe House 412 Windward Way Kalispell, MT 59840 West House 1404 Westward Dr. Hamilton, MT 59801 Recovery Center 1201 Wyoming St. Missoula, MT 59801	

Steps for State Approval

1. Complete the State Approval Application and submit to AMDD. Application can found here, https://dphhs.mt.gov/amdd/substanceabuse/ProviderForms
    - Three types of state approved program
        - Prevention (Prevention + Early Intervention)
        - Outpatient Provider (Individual LAC)
        - Substance Use Disorder (SUD) Facility (Specialty services beyond typical outpatient therapy)
    - Copy of Policy and Procedures addressing ARM 37.27.101 through 37.27.138; CFR 42 and 45
    - Copy of Health Care Facility License for inpatient and residential programs (ASAM 3.1 – 3.7)
    - Documentation demonstrating local need for each county seeking state approval
    A detailed narrative outlining local need for chemical dependency treatment services currently exists for each county where the Applicant proposes to provide chemical dependency treatment services is required. The narrative must include county level data references to support the need for chemical dependency treatment services applicant proposes to provide. State level data is not accepted as a demonstration of local need.
    - Projected services for each county seeking state approval

2. AMDD determines limited (provisional) State Approval and sends a letter to the provider.

3. If applicant is a SUD facility, the Provider is required to schedule a site visit with Office of Inspector General for full State Approval.

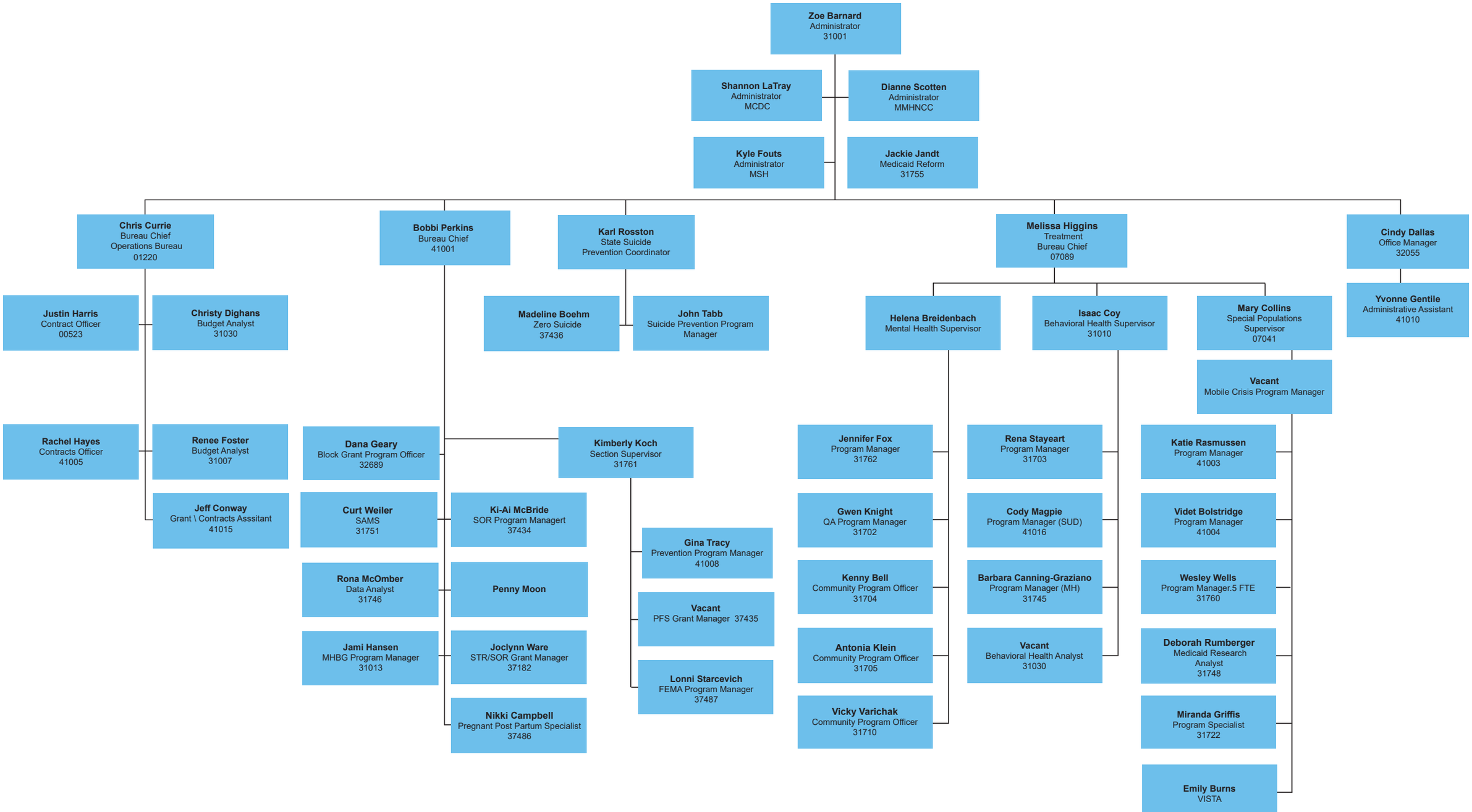
4. If the applicant is a prevention or outpatient provider, the provider is required to schedule a documentation review with AMDD, either on-site or remotely for full State Approval.

5. Full State Approval is determined by QAD or AMDD depending on the type
    - Full State Approval letter sent by AMDD
    - Certificate provided by QAD
    - Applicant can now enroll in Medicaid as Provider Type 32

6. Annual site visits conducted to ensure compliance with applicable regulations.

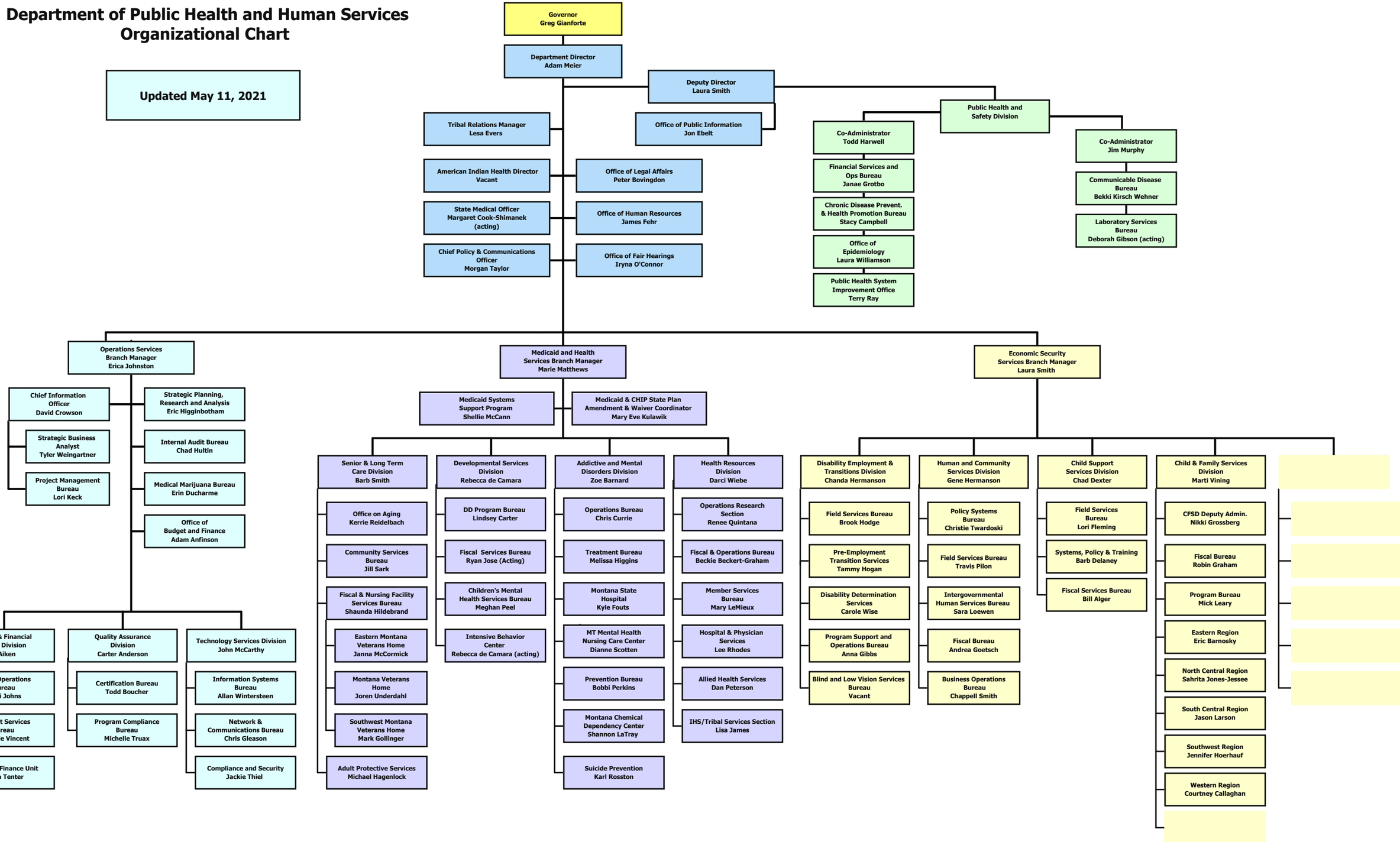
Three advantages of state approval:
1. Access to Substance Abuse Block Grant (SABG) funding. State approved providers can submit a BG contract application through RFP each year (for non-Medicaid covered services up to 200% FPL)
2. Access to alcohol tax dollars. 20% of generated alcohol tax dollars are distributed to counties and only state approved SUD providers can receive those funds. Funds must be used for SUD prevention, treatment, and recovery services.
3. Per 61-8-732, MCA, DUI education and assessments must be performed by an LAC at an approved program (currently this is inclusive of the state approved SUD providers)

AMDD


Zoe Barnard
Administrator
31001
Shannon LaTray
Administrator
MCDC
Dianne Scotten
Administrator
MMHNCC
Kyle Fouts
Administrator
MSH
Jackie Jandt
Medicaid Reform
31755
Chris Currie
Bureau Chief
Operations Bureau
01220
Bobbi Perkins
Bureau Chief
41001
Karl Rosston
State Suicide
Prevention Coordinator
Melissa Higgins
Treatment
Bureau Chief
07089
Cindy Dallas
Office Manager
32055
Justin Harris
Contract Officer
00523
Christy Dighans
Budget Analyst
31030
Madeline Boehm
Zero Suicide
37436
John Tabb
Suicide Prevention Program
Manager
Helena Breidenbach
Mental Health Supervisor
Isaac Coy
Behavioral Health Supervisor
31010
Mary Collins
Special Populations
Supervisor
07041
Yvonne Gentile
Administrative Assistant
41010
Vacant
Mobile Crisis Program Manager
Rachel Hayes
Contracts Officer
41005
Renee Foster
Budget Analyst
31007
Dana Geary
Block Grant Program Officer
32689
Kimberly Koch
Section Supervisor
31761
Jennifer Fox
Program Manager
31762
Rena Stayeart
Program Manager
31703
Katie Rasmussen
Program Manager
41003
Jeff Conway
Grant \ Contracts Assitant
41015
Curt Weiler
SAMS
31751
Ki-Ai McBride
SOR Program Managert
37434
Gwen Knight
QA Program Manager
31702
Cody Magpie
Program Manager (SUD)
41016
Videt Bolstridge
Program Manager
41004
Rona McOmber
Data Analyst
31746
Penny Moon
Gina Tracy
Prevention Program Manager
41008
Kenny Bell
Community Program Officer
31704
Barbara Canning-Graziano
Program Manager (MH)
31745
Wesley Wells
Program Manager.5 FTE
31760
Jami Hansen
MHBG Program Manager
31013
Joclynn Ware
STR/SOR Grant Manager
37182
Vacant
PFS Grant Manager 37435
Antonia Klein
Community Program Officer
31705
Vacant
Behavioral Health Analyst
31030
Deborah Rumberger
Medicaid Research
Analyst
31748
Nikki Campbell
Pregnant Post Partum Specialist
37486
Lonni Starcevich
FEMA Program Manager
37487
Vicky Varichak
Community Program Officer
31710
Miranda Griffis
Program Specialist
31722
Emily Burns
VISTA

Department of Public Health and Human Services Organizational Chart

Updated May 11, 2021



Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

MONTANA
PLANNING STEP 2
SABG FY 2022-2023 APPLICATION

Identify the unmet service needs and critical gaps within the current system.

Data Collection and Reporting System – Identifying Priorities
Montana is working continuously to analyze MH and SUD data to identify and monitor service needs and gaps, to ensure the prevention, treatment and recovery strategies are available to individuals targeted by the SAMHSA Block Grants. These following data systems are used and highlight health disparities, service gaps and behavioral health needs in MT.

NSDUH Data

In 2018-2019, SAMHSA estimated that 94,000 Montanans aged 12 or more years needed, but were unable to receive, treatment at a specialty facility for substance use in the past year. This describes 10% of the Montanan population in this age range. Whereas 9% of single-race non-Hispanic White (NHW) Montanans fall into this treatment gap, the prevalence among single-race non-Hispanic American Indians/ Alaskan Natives (NHAIAN) is twice as high (19%). By age, 16% of Montanans aged 18-25 years were unable to receive needed treatment in the past year, followed by 10% of Montanans aged 26 or more years, and then 6% of Montanans between 12-17 years of age. The prevalence among males was 12%, while the prevalence among females was 9%.

2018-2019 NSDUH Data estimates that 17,000 Montanans between the ages of 18-25 years (15%) and 132,000 Montanans aged 26 or more years (19%) received any form of mental health treatment in the past year. Still, 44,000 Montanans experienced unmet mental health needs during this same period. Among these Montanans with unmet mental health needs, reasons for not receiving needed treatment included inability to afford it (49%), lack of time (19%), insurance not paying enough (14%), insurance not covering it (13%), and lack of transportation (4%).

TEDS

In 2020, TEDS (Treatment Episode Data Set) reported 1157 admissions to treatment. The top five primary drug of choice for this population were Alcohol, Amphetamines, Marijuana, Heroin, and Opiates. For this population, 60 percent were male and 40 percent female. The admissions included the following top five age brackets: 21-25 (12.4 %); 26-30 (20.7%); 31-35 (16.2%); 36-40 (17.9%); 41-45 (9.1%). Races for these admissions included 66% White, 1.6 % Black or African American, 24.9% American Indian or Alaska Native, .4% Asian or Native Hawaiian or Other Pacific Islander, 4.7% Other, and 1.9% unknown. Of this population .8% were pregnant, 11.2% were women with children, 23.4% were homeless, and 31.2% were admission with co-occurring diagnosis.

N-SSATS

In 2020, Montana had 4,976 clients enrolled in 129 treatment facilities. 297 clients were under the age of 18 years, including 281 in facilities offering special programs or groups for adolescents.

State Health Assessment (Attached

The highlights from the State Health Assessment from 2017 for behavioral health include:

- Nearly one in ten (9%) Montanans have a substance use disorder. Young adults (aged 18–25 years) in Montana rank among the highest nationwide for Alcohol Use Disorder (14%) and Alcohol Dependence (6%).
- Deaths from opioid misuse in Montana peaked in 2009 and decreased to 4 deaths per 100,000 in 2015.
- From 2011–2015, Montana's suicide rate was nearly two times higher than the U.S. On average, 240 suicides occur each year in Montana and 990 emergency department visits for suicide attempts. Suicide rates did not differ significantly by race; however, suicide was significantly higher among veterans compared to non-veterans and residents of rural counties compared to micropolitan counties.
- Many Montanans who need mental health and substance use disorder treatment do not receive treatment. During 2015 and 2016, an estimated 72,000 Montanans aged 12 years and older needed but did not receive treatment for substance use in the past year.

2019 Behavioral Health Barometer, Volume 6 (Attached)

Highlights from the 2019 MT Behavioral Health Barometer highlights the major concerns:

Among youth aged 12–17 in Montana, the annual average percentage of alcohol use in the past month decreased between 2002–2004 and 2017–2019. During 2017–2019, the annual average prevalence of past-month alcohol use in Montana was **13.5%** (or **10,000**), higher than both the regional average (**8.5%**) and the national average (**9.4%**)

Among youth aged 12–17 in Montana, the annual average percentage with an MDE in the past year increased between 2004–2007 and 2016–2019. During 2016–2019, the annual average prevalence of past-year MDE in Montana was **13.8%** (or **10,000**), like both the regional average (**14.2%**) and the national average (**14.0%**).

Among young adults aged 18–25 in Montana, the annual average percentage of binge alcohol use in the past month did not significantly change between 2015–2017 and 2017–2019.
During 2017–2019, the annual average prevalence of past-month binge alcohol use in Montana was **45.7%** (or **50,000**), higher than both the regional average (**36.3%**) and the national average (**35.4%**).

Among adults aged 18 or older in Montana, the annual average percentage with AMI who received mental health services in the past year did not significantly change between 2008–2010 and 2017–2019. During 2017–2019, the annual average prevalence of past-year mental health service use among those with AMI in Montana was **47.6%** (or **80,000**), similar to both the regional average (**47.0%**) and the national average (**43.6%**).

2020/2021 DPHHS SEOW Surveillance Reports

Youth Drinking and Driving (February 2020): This report describes the prevalence and trends of alcohol impaired driving throughout the state based on YRBS data, including at substate levels of granularity. It additionally identifies actions for parents, health care providers, and public health professionals on what can be done to reduce this behavior.

Use of E-Cigarettes and Marijuana Among Montana High School Students (March 2020): The purpose of this surveillance report is to describe the use and trends of e-cigarette and marijuana use among high

school students in Montana. It additionally identifies actions for parents, health care providers, and public health professionals on what can be done to reduce this behavior.

Summary of Methamphetamine Use in Montana (August 2020): This report describes what is known about illicit methamphetamine use in Montana, given the available data. This report also identifies data limitations and gaps relevant to illicit methamphetamine surveillance in the state.

Youth Cannabis Consumption (November 2020): This report describes the prevalence and trends of cannabis/ marijuana use throughout the state based on YRBS data, including at substate levels of granularity. It additionally identifies actions for parents, health care providers, and public health professionals on what can be done to reduce this behavior.

Alcohol Use in Montana (January 2021): One page fact sheet describing the prevalence and effects of alcohol use in Montana.

Cannabis Use in Montana (January 2021): One page fact sheet describing the prevalence and effects of cannabis/ marijuana use in Montana.

Heroin Use in Montana (January 2021): One page fact sheet describing the prevalence and effects of heroin use in Montana.

Meth Use in Montana (January 2021): One page fact sheet describing the prevalence and effects of methamphetamine use in Montana.

Opioid Use in Montana (January 2021): One page fact sheet describing the prevalence and effects of opioid use in Montana.

Other State Data

According to reports from the Montana Office of Epidemiology and Scientific Support released in January of 2021:

- Montana's opioid-related overdose deaths has increased since 2017 from 2.3 per 100,000 to 4.8 per 100,000 in 2019.
- Between 2018 and 2019, over 36,000 Montanans 12 years or older reported having misused opioids within the past year.
- One third of high school students reported using alcohol within the last month and 50% of those individuals also reported engaging in binge-drinking behavior.
- 14% of adults Montanans reported driving under the influence of alcohol between 2017 and 2018. This is significantly higher than the national average during the same time period: 9%.
- In the year 2018, of all the traffic fatalities in the state, 37% were alcohol related.
- In 2019, most of all EMS activation related to substance use involved alcohol (79%).

Summary of Unmet Service Need & Gaps in Montana:

PRIMARY PREVENTION

Data are collected from the Youth Risk Behavior Survey (YRBS), Prevention Needs Assessment (PNA), National Survey on Drug Use and Health (NSDUH), and Behavioral Risk Factor Surveillance System (BRFSS) to report on current alcohol use, current binge drinking, and current marijuana use. Current alcohol use refers to the consumption of alcohol at least once in the past 30 days. Current binge drinking then builds upon this to describe engaging in a pattern of drinking in which 4 or more (for women), or 5 or more (for men), alcoholic beverages within a couple of hours at least once in the past 30 days. Like current alcohol use, current marijuana use refers to the use of marijuana at least once in the past 30 days.

The YRBS monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults, including (1) behaviors that contribute to unintentional injuries and violence, (2) sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection, (3) alcohol and other drug use, (4) tobacco use, (5) unhealthy dietary behaviors, and (6) inadequate physical activity. Montana high school students in grades 9-12 take part in the YRBS on odd numbered years, during which the survey is administered as a pen and paper questionnaire; this Centers for Disease Control and Prevention (CDC) survey is coordinated through the Montana Office of Public Instruction (OPI).

The PNA was designed to measure the need for prevention services among youth in the areas of substance abuse, delinquency, antisocial behavior, and violence. The questions on the survey ask youth about the factors that place them at risk for substance use and other problem behaviors along with the factors that offer them protection from problem behaviors. The survey also inquires about the use of alcohol, tobacco, and other drugs (ATODs) and participation in various antisocial behaviors. Montana's Addictive and Mental Disorders Division (AMDD) administers the PNA on even numbered years, surveying Montana students in grades 7-12; the primary sample is 8, 10, and 12 grade students. Unlike the other survey data featured here, this survey does not feature a national average for comparison.

The NSDUH provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States. Information from NSDUH is used to support prevention and treatment programs, monitor substance use trends, estimate the need for treatment and inform public health policy. The Substance Abuse and Mental Health Services Administration (SAMHSA) directs the NSDUH survey which is conducted annually by RTI International as an interview among a sample of randomly selected households, interviewing no more than two people per household ages 12 years and above.

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual state-based surveillance system of phone surveys conducted in collaboration with the CDC and coordinated through MT DPHHS Public Health and Safety Division (PHSD), Office of Epidemiology and Scientific Support (OESS). The BRFSS gathers information about health, health risk behaviors, preventative practices, and health care access from non-institutionalized adults ages 18 and older. In addition, information on a variety of demographic factors is gathered to obtain prevalence estimates for specific population sub-groups.

Statement of Need

Underage Drinking

In the 2019 YRBS, 33% of Montana high school students reported current alcohol use, and 18% reported current binge drinking. In comparison, the prevalence of current alcohol use among high school students nationwide was 29%, and the prevalence of current binge drinking was 14% for the same survey cycle.

The 2018-2019 NSDUH estimates that 12% of Montana youth between the ages of 12-17 years currently used alcohol and 6% engaged in current binge drinking. National estimates were once again lower than Montana's state estimates, with 9% of youth between the ages of 12-17 years estimated to have engaged in current alcohol use and 5% engaging in binge drinking.

Finally, the 2020 PNA found that 29% of Montana 8th, 10th, and 12th grade students currently drank alcohol among its weighted sample.

Adult Binge Drinking

According to the 2020 BRFSS, the crude prevalence of binge drinking among Montana adults age 18 years or more was 20%; the age-adjusted prevalence was 22%. The national median for the crude prevalence of this behavior was 16%; a median age-adjusted prevalence is not available at this level.

Youth Marijuana Use

The 2019 YRBS reports that 21% of Montana high school students engaged in current marijuana use; this was not significantly different from the national prevalence of 22% (p=0.66).

The 2018-2019 NSDUH estimates that 10% of Montana youth between the ages of 12-17 years engaged in current marijuana use. The national prevalence for the same age group was 7%.

In the weighted sample from the 2020 PNA, 14% of Montana 8th, 10th, and 12th graders reported current marijuana use.

Adult Marijuana Use

The 2018 BRFSS reported that 14% of Montana adults aged 18 years or more engaged in current marijuana use. This optional module of the BRFSS does not offer a national comparison.

The 2018-2019 NSDUH data estimates that 16% of Montana adults aged 18 years or more engaged in current marijuana use. The national prevalence for this time was 11%.

Summary

Alcohol and marijuana are among the most consumed substances in Montana. The prevalence of alcohol consumption in Montana has historically been higher than the national average among both youth and adults. Beginning in 2021 a licit market for the retail purchase of marijuana will open in Montana. In preparation for this, AMDD and DPHHS have begun new surveillance efforts and increased

existing surveillance efforts to monitor this drug more closely. A novel web survey will be administered between October-December 2021, recruiting youth and adults in Montana to establish baseline knowledge about marijuana consumption behaviors, risky behaviors associated with marijuana use, and knowledge about Montana laws surrounding marijuana consumption. This new survey will ask about indicators not normally featured on other surveys, such as the dose and amount spent on marijuana, allowing us to fill in these data gaps. Additionally, the optional Marijuana Use module featured for the BRFSS has increased in frequency, from being administered on even numbered years only to being administered annually.

TREATMENT

Based upon the data and statistical information produced, there are 1 in 10 (9%) Montanans in need of some type of substance abuse/misuse treatment. The current system is challenged in addressing these service needs due to the following issues:

1. Behavioral Health Workforce is limited, particularly in rural & frontier areas
2. Inadequate funding for behavioral health services
3. Lack of utilization of evidence-based programming with fidelity

Montana continues to work on the development of a continuum of services within our state. The critical gaps in services are as follows:

1. Early identification and brief intervention of mental health and/or substance misuse.
2. Available recovery residences for individuals discharging from ASAM Level 3.5 or 3.1 residential treatment.
3. Community based detox services throughout the state.
4. Medication assisted treatment and behavioral health services in detention centers, emergency department, hospitals and other health care facilities
5. A continuum of services that is accessible throughout all 56 counties – a regional system that would allow people to access all levels of services on a regional basis rather than in one or two major cities in Montana.

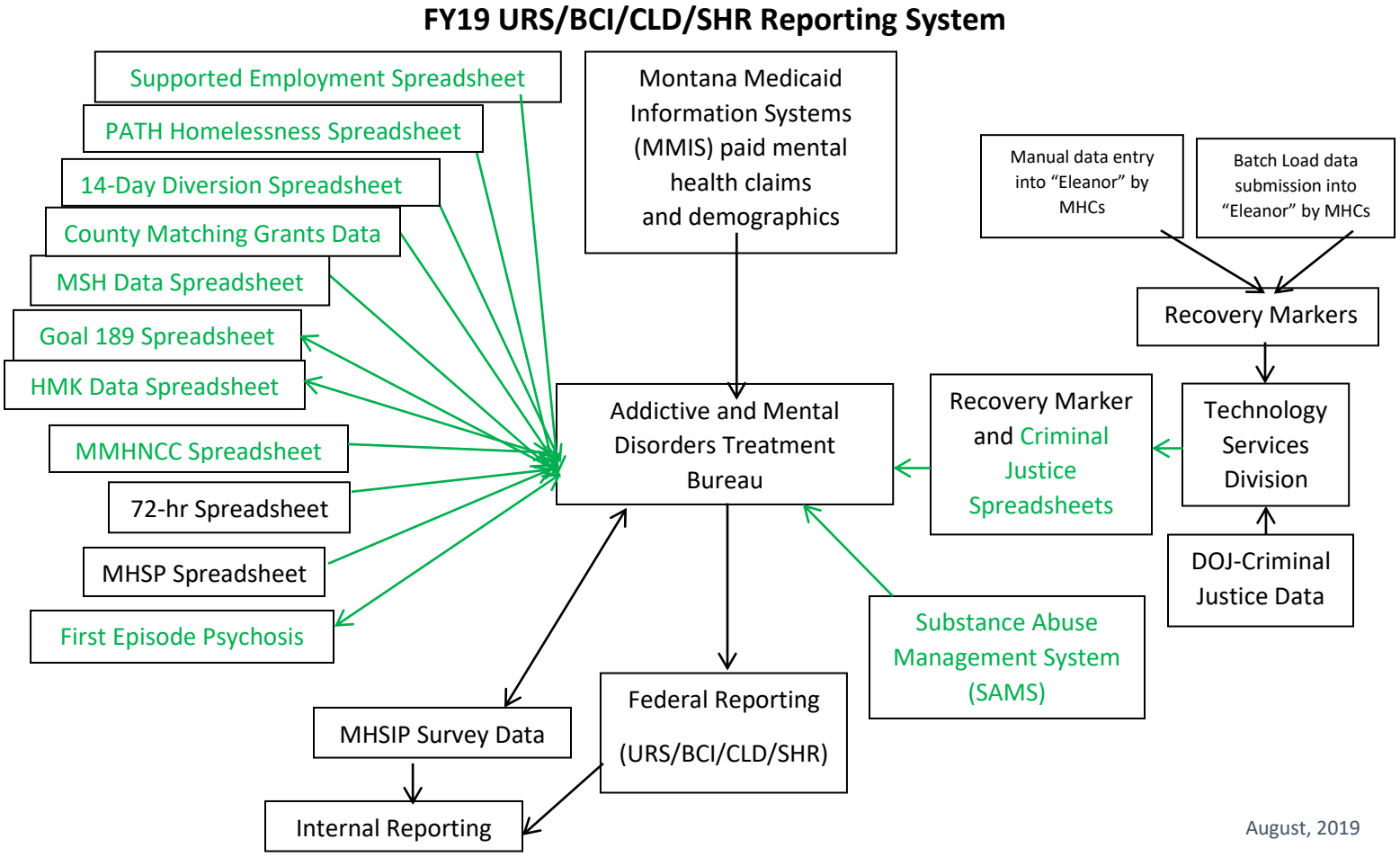
Overview of Montana's Data Collection System

Montana's primary data collection system is the Medicaid Management Information System (MMIS) which processes Medicaid claims for Montana Medicaid. This system provides client level data to include Medicaid number, name, address, phone number, gender, date of birth, and diagnosis. In addition to client level data, the MMIS allows for provider data which includes provider type, NPI, location, and services billed. Through the MMIS we can run data queries which allows us to project Medicaid funding, review services for utilization, and identify any irregularities. There are inherent limitations on reporting through this system. Providers have 365 days to bill for Montana Medicaid which means it may be over a year before we have completely accurate historical data.

In addition to the MMIS, the Montana Substance Abuse Management System (SAMS) is administered by the Addictive and Mental Health Disorders Division of the Montana Department of Public Health & Human Services and is a required reporting process for all (contracted) state approved chemical dependency programs. The SAMS information is used for planning, invoicing, reports and reporting, client case management, as well as the Prevention Bureau's management and evaluation of program effectiveness. The SAMS system has been designed to allow state approved chemical dependency programs to provide client services data to the Department of Public Health and Human Services, who in turn report the data to the federal government on a monthly basis for the Treatment Episode Data Set (TEDS). TEDS data includes National Outcomes Measures (NOM) data elements and admission/discharge data sets.

The Home and Community Based Services SDMI Waiver utilizes both an incident management system and a care management system. The Person-Centered Recovery Plan (PCRP) is entered into the care management system. Collection of this client level data allows the case management teams and the state to active management waiver members.

The following diagram provides a brief overview:



Eleanor = Data collection system that includes the web-based Recovery Marker program
HELP = Medicaid plan administered by Blue Cross Blue Shield of MT through 12/31/17
HMK = Healthy MT Kids / CHIP
MHCs = Mental Health Centers
MHSB = Mental Health Services Bureau
MHSP = Mental Health Services Plan
MICRS = Management Information and Cost Recovery System (MSH data source, not used with manual submission; spreadsheet from MSH used instead)
MMHNCC = MT Mental Health Nursing Care Center
MMIS = MT Medicaid Information System
MSH = MT State Hospital

NOTE: Green text shows additional data sources used for MHSB manual submission vs. submission by TSD.

On the treatment side, Montana currently has a data collections system that was developed within the state system called SAMS (Substance Abuse Management System) which was built to report data into the TEDS system and invoice for services provided by the SAPT Block grant. It collects all the required data for TEDS. Data can be reported at all levels (client, program, provider, regional, state, or other defined areas). The system itself is tied into several eligibility systems within Montana – for example the demographic information of name, address, etc. is tied into a system used statewide for such things as WIC, Medicaid, etc. and is very difficult to modify in certain areas because of the effect on other systems. The system information (so treatment information) cannot be accessed or viewed by any other personnel from other state entities.

The prevention data is collected by the FEI System Inc. through their WITTs system. As of July 2016, Montana is utilizing the FEi Systems WITS (Web Infrastructure Treatment System) for data collection and reporting. WITS satisfies mandatory government reporting requirements for Primary Prevention Programs. We can retrieve information using the FEI WITS reporting tool and report out on a program level, provider level and funding level. We can pull data from the Planned Strategies, Implemented Strategies including funding, sessions (one-time, recurring or session-based) and activities. We use the standard Block Grant reports Tables 31, 32,33,34,35, Table 9, Table 5a, Table 5b as supplied with the FEi WITS systems Basic Service Package. These reports have already been through a rigorous testing. Currently, we are not using the web-based software to track early intervention services (Clients or Groups) as they are a part of the enterprise data model.

Montana's State Epidemiological Outcomes Workgroup (SEOW), over the past years, has undertaken the process of conducting a comprehensive needs assessment that developed the priorities and contracts for prevention by following the SEOW task list. The following steps describe the processes taken to prioritize MT data that define the current priorities in contractual requirements through FFY 20:

1. Identify data sources and collect database of sources for alcohol, tobacco, and other drugs (ATOD) consumption and consequence patterns.

2. Develop list of consumption and consequence indicators. Databases associated with chosen data sources were evaluated for their immediate relevance to Montana's Substance Abuse prevention activity with the goal to tease out a reduced number of indicators. Databases not only had to meet the above criteria for their sources but also had to show:

The SEOW group made the recommendation of focusing efforts on Binge drinking and drinking and driving. When they reviewed this data, they also prioritized the counties (our definition of communities) in most need - thus identifying where our focus for both prevention and treatment is needed.

In reviewing areas of most need from the epi report and our current system of treatment, we are missing a continuum of care throughout those areas identified as high risk. There continues to be a lack of services, lack of evidence-based programming to address both binge drinking and drinking and driving, and a lack of a responsive system to changing ATOD issues.

These priorities then drop down into the treatment portion. We are looking at supports for residential services, coordination of treatment services with corrections, addressing co-occurring disorders, and working with American Indians (our reservations have some of the highest rates of both binge drinking and drinking and driving). Coordination of treatment services with corrections will further address DUIs and the continuum from prison to the community. Additionally, we are focusing on co-occurring disorders as we are finding that many binge drinking episodes are linked to a co-occurring or lack of medication issue. Substance use disorder prevention activities are focused on working to address the identified priorities through the implementation of evidence based environmental and coalition building programing, thus addressing binge drinking and drinking and driving. Montana continues work to add more mental health and primary health care issues to this picture. Data efforts and review progress in the priorities will keep growing and changing to meet the changing needs of the population.

Services and Supports Provided Towards Integrated Systems of Care to Address Needs and Gaps

AMDD is responsible for managing reimbursement for Medicaid and other federal and state funded services for SUD and is working towards integration of SUD and adult mental health services. AMDD currently restructured to include both SUD and adult mental health treatment services under one bureau.

In 2018, AMDD amended reimbursement methodologies for SUD assessment, individual therapy, and group therapy from the Healthcare Common Procedure Coding System (HCPC) to the national standard Current Procedural Terminology (CPT) codes. The change from HCPC codes to CPT codes aligned service requirements and reimbursement methodology for substance use disorder treatment providers with other behavioral health professionals, including mental health professionals.

Further alignment took place in 2018, when AMDD created the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health. The manual provides services definitions, provider requirements, and services requirements for both SUD and adult mental health Medicaid funded services in one location. General requirements have been normalized between SUD and adult mental health and include assessments and individualized treatment planning. This sets the foundation to support co-occurring services.

In 2019, AMDD created tiered bundled rates for Intensive Outpatient (IOP) Therapy for SUD treatment to support access to IOP, which included an add on enhancement for co-occurring mental health treatment. In addition, in the 2019 Montana Legislative session, funding was provided for mental health certified peer support services as part of Montana's Medicaid service array. AMDD chose to also fund certified peer support services for SUD and submitted a state plan amendment to add Certified Behavioral Health Peer Support for both SUD and adult mental health to the Medicaid service array. Co-occurring Certified Behavioral Health Peer Support services will be monitored moving forward.

Individuals with SMI and SUD in the Workforce

MT is expected to experience a critical shortfall of workers over the next 10 years. According to the *Missoulian,* "Due to an aging population and faster-than-average economic growth rates, MT's labor force is not expected to keep up with businesses' demand for workers over the next 10 years. MT's labor force is about 500,000 workers right now, but the State is expected to lose 120,000 baby boomers to retirement over the next decade." With only 80,000 to 90,000 younger workers entering into the MT work force, businesses can't find enough skilled workers.

NAMI's current national data shows that SMI costs America $193.2 billion in lost earnings per year. Employment for those with SMI is an essential part of recovery as well as being a cost-effective alternative to day treatment. Steady employment improves self-esteem and social networks. It increases quality of life and reduces SUD and use of mental health services. Research done by the MT Center for Mental Health Uniform Reporting System, shows that 66

percent of individuals with a SMI say they want to work however, only less than 20 percent are working.

Supported Employment may be the answer to both MT's skilled worker shortage as well as the nation's lost earnings. Supported Employment refers to services provided to an individual with a SMI to assist them in obtaining and maintain competitive employment. Currently, supported employment is funded through the MHBG.

FEP

Research done by The National Institute of Mental Health (NIMH) has shown, "that if left untreated, young adults experiencing psychosis are more likely to develop SMI such as schizophrenia." Additional research done by the MT Office of Public Instruction found results from the Youth Risk Behavior Survey (YRBS) shows that in the past decade, the percentage of youth who reported sad or hopeless feelings for 2 or more weeks in a row during the past 12 months increased from 27.3% in 2009 to 36.7% in 2019. However, according to NAMI, only 51 percent for youth aged 8-15 received mental health services in the previous year. Youth and adolescents who do not receive mental health services show a greater decrease in functioning such as:

- Loss of educational opportunities
- Impaired psychosocial and vocational development
- Personal suffering/family burdens; and
- Potential poorer response once treatment is provided.

To address these issues, the AMDD is working to improve early access to behavioral health services by providing FEP services to 16-25 years old experiencing FEP.

Early Psychosis Intervention Clinic (EPIC) is a partnership between Billings Clinic, a nonprofit integrated health system located in Billings, South Central MT Regional Mental Health Center, and NAMI MT. They have chosen to use Yale's Specialized Treatment Early in Psychosis (STEP) model, which is based on an interdisciplinary team approach to providing comprehensive care for individuals early in the onset of a psychotic illness. STEP starts with thorough assessment in order to gain the best understanding of what may be causing the individual's difficulties. Then, based upon individual needs and preferences, treatment may include medication management, community coaching, individual and group therapy, as well as support and education for family members and friends. The goal of EPIC is, "To measurably improve outcomes for individuals within our 6 MT county service area (Gallatin, Park, Sweet Grass, Stillwater, Carbon, and Yellowstone), aged 16-25, who experience a recent onset of psychosis by accelerating and increasing access to coordinated specialty care."

Individuals Who Are Experiencing Homelessness

According to NAMI, an estimated 26 percent of homeless individuals staying in shelters live with SMI and an estimated 46 percent live with severe mental illness and/or SUDs. MT's 2016 PIT count identified 1,486 individuals who were homeless on January 28, 2016. Of those individuals identified as homeless, 298 are living with a SMI and 186 identified as chronic substance users. In MT's fight to reduce or eliminate homelessness for individuals with SMI or

co-occurring SMI and SUDs or who are at imminent risk of becoming homeless, PATH funds are used to provide a menu of required services, which are not supported by mainstream programs. Through its services, PATH links a vulnerable population who experience persistent and pervasive health disparities to mainstream and other supportive services. Collectively, these efforts help homeless individuals with SMI secure safe and stable housing, improve their health, and live a self-directed, purposeful lives. The PATH Program is part of SAMHSA's Recovery Support Strategic Initiative which includes goals to improve the physical and behavioral health of individuals with behavioral health disorders, increase access to permanent housing, increase attainment of employment, and increase social supports.

In MT, PATH Programs serve as the front door to Continuum of Care (CoC) services and to mainstream behavioral health, primary health care, and substance abuse service systems. MT PATH Programs use existing capacities to leverage services and supports or propose ways that this capacity will be developed, i.e., through community CoC committees. MT PATH Programs are more than a stand-alone response to the needs of MT PATH Program eligible individuals and MT PATH Program funds are used in projects that link with other services and providers to develop comprehensive approaches to community services. Below is a list of required services PATH funds are used for:

- Evidenced based outreach approaches
- Enrollment in MT PATH Program
- Case management for at least 3 months
- Prescription renewal.
- Medication management.
- Referral to community behavioral health services, including support services.
- Referral to primary health services, dental services, job training, education services, and housing services; and
- Case management intake, prescription renewal, and medication management services.

Medications play an important part of an individual's treatment plan and are usually more effective when combined with psychotherapy. According to NAMI, "In some cases, medication can reduce symptoms so that other methods of a treatment plan can be more effective. For example, a medication may alleviate some significant symptoms of major depression and then talk therapy can help you change negative patterns of thinking." For these reasons, AMDD has chosen to use MHBG funding to support the MT PATH Program.

Women with Dependent Children & Pregnant Women

SAMHSA identifies 5 primary populations and service areas that have been deemed "Target Populations" due to the fact that these populations tend to be underserved. One of these vulnerable populations is dependent children and pregnant women. The National Survey on Drug Use and Health reports that throughout the country, 5.8% of pregnant women use illicit drugs (marijuana, cocaine, opioids), 9.6% use tobacco products, and 9.5% use alcohol while pregnant. Regarding women with dependent children, the National Center for Substance Abuse and Child Welfare reports that 1 in 8 children live in a household in which at least one parent has a substance use disorder. Further, pregnant women and women with dependent children who engage in substance misuse often do not seek help due to fear of prosecution for illicit drug use, which is why Montana passed SB289 during the 2019 legislative session. This bill provides pregnant women seeking assistance with a substance use disorder safe harbor from prosecution.

Despite the legislative developments, Montana's pregnant women and women with dependent children still remain underserved.

Montana has expanded the number of residential treatment facilities that serve pregnant and/or women with dependent children in the past 3 years. There are now 4 residential treatment facilities with 33 beds.

Behavioral Health Peer Support Specialists

According to the United States Health Resources and Services Administration, all of MT's 56 counties have been designated as health care provider shortage areas for behavioral health services. In fact, MT has the largest and most severe behavioral health shortage in the entire United States. "The eastern MT Mental Health Professional Shortage Areas includes 78,607 MT Residents and is spread over 17 counties and 47,945 square miles." (Attachment B, MT Health Care and Innovation Plan) The lack of community based behavioral health services can be detrimental for individuals with SMI. This statistic is exemplified when comparing the number of Montanans with SMI who are receiving Illness Self-Management and Recovery services.

To address the need for accessible, affordable behavioral health services, the 2019 MT Legislature passed a law, which provided for the reimbursement of Behavioral Health Peer Support Specialist Services. A Behavioral Health Peer Support Specialist is an individual with lived experience who supports other individuals recovering from behavioral health issues. Because of their lived experiences, Behavioral Health Peer Support Specialists are able to share expertise that professional training cannot replicate.

According to SAMHSA, Peer Support Services designed and delivered by Behavioral Health Peer Support Specialists have been proven to be successful in the recovery process, as well as extremely cost effective.

- Helping individuals in with SMI: navigate community mental health services.
- Providing access to mental health services at the grassroots level.
- Providing rural access to someone in the behavioral health field; and
- Advocating for veterans in mental health crisis.

The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. Jim Hajny, Executive Director of MT Peer Network, adds that by including Behavioral Health Peer Support Specialists within the framework of the mental health system we send the message, "recovery is possible" to individuals with SMI.

MT's adoption of the recovery model for adults with SMI has signaled a major shift in paradigms for the treatment of mental illness and substance use disorders. According the SAMHSA, "Today, when individuals with mental illness/or substance use disorder seek help, they are met with the knowledge and belief that anyone can recover and/or manage their conditions successfully." Placing recovery at the center of the treatment plan allows individuals to focus on the resiliency of recovery rather than in the pathology of SMI and substance use disorder. To assist in the adoption of the recovery model, MT will be using a portion of the

MHBG to provide Behavioral Health Peer Support Services and training throughout the State, to improve the integrity, supervision, and support to Behavioral Health Peer Support Specialists.

Integrated Reimbursement for SUD Intensive Outpatient Therapy with enhanced rate for Co-Occurring

AMDD is responsible for managing reimbursement for Medicaid and other federal and state funded services for SUD and is working towards integration of SUD and adult mental health services. AMDD currently restructured to include both SUD and adult mental health treatment services under one bureau.

In 2018, AMDD amended reimbursement methodologies for SUD assessment, individual therapy, and group therapy from the Healthcare Common Procedure Coding System (HCPC) to the national standard Current Procedural Terminology (CPT) codes. The change from HCPC codes to CPT codes aligned service requirements and reimbursement methodology for substance use disorder treatment providers with other behavioral health professionals, including mental health professionals.

Further alignment took place in 2018, when AMDD created the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health. The manual provides services definitions, provider requirements, and services requirements for both SUD and adult mental health Medicaid funded services in one location. General requirements have been normalized between SUD and adult mental health and include assessments and individualized treatment planning. This sets the foundation to support co-occurring services.

In 2019, AMDD created tiered bundled rates for Intensive Outpatient (IOP) Therapy for SUD treatment to support access to IOP, which included an add on enhancement for co-occurring mental health treatment. In addition, in the 2019 Montana Legislative session, funding was provided for mental health certified peer support services as part of Montana's Medicaid service array. AMDD chose to also fund certified peer support services for SUD and submitted a state plan amendment to add Certified Behavioral Health Peer Support for both SUD and adult mental health to the Medicaid service array. Co-occurring Certified Behavioral Health Peer Support services will be monitored moving forward.

Mental Health Training and Educational Opportunities

The number of individuals accessing mental health services in MT has steadily increased from 38,031 in 2013 to 49,935 in 2016. This increase in utilization of services correlates with the increase in the number of Montanan's who have taken part mental health training and educational opportunities offered across the State offered by AMDD and NAMI MT.

AMDD and NAMI MT have enjoyed a close affiliation for many years. Together they have worked to eliminate the stigma of mental illness and to improve the care and treatment of individuals with mental illness. This year AMDD will contract with NAMI MT to use the MHBG to:

- Provide scholarships to individuals to the NAMI MT State Conference on Mental Illness.
- Bring in national speakers to the NAMI MT conference.
- Send individuals to the National NAMI Headquarters for Train the Trainer opportunities.
- Provide Continuing Educational Units (CEU) to mental health providers; and
- Offer a variety of educational programs, free of charge, to communities across the State.

CONCLUSION

Montana continues to work and focus on the following behavioral health needs by identifying the critical gaps and strategies across the continuum. As outlined in the State Health Improvement Plan (Attached), some of the critical gaps are being addressed through:

1. Early screening for depression and substance misuse within primary care settings.
2. Improved care coordination and integration of physical and behavioral health.
3. Community based crisis and detox services throughout the state.
4. Promoting Medication assisted treatment.
5. A continuum of services that includes peer support to ensure services are accessible throughout all 56 counties – a regional system that would allow people to access all levels of services on a regional basis rather than in one or two major cities in Montana through telemedicine and other innovative technologies.
6. Improving Workforce (both in number of people and the knowledge/education).
7. Funding.
8. Medical coding ability (which supports billing third party payers).
9. Understanding of implementation and fidelity of evidence-based programming.
10. Knowledge base of business operations.

Additionally, the State Epidemiological Outcomes Workgroup (SEOW) has reconfigured to be an internal workgroup to DPHHS and AMDD. The SEOW includes data experts from various agencies and divisions who manage data systems that align with behavioral health and include the following:

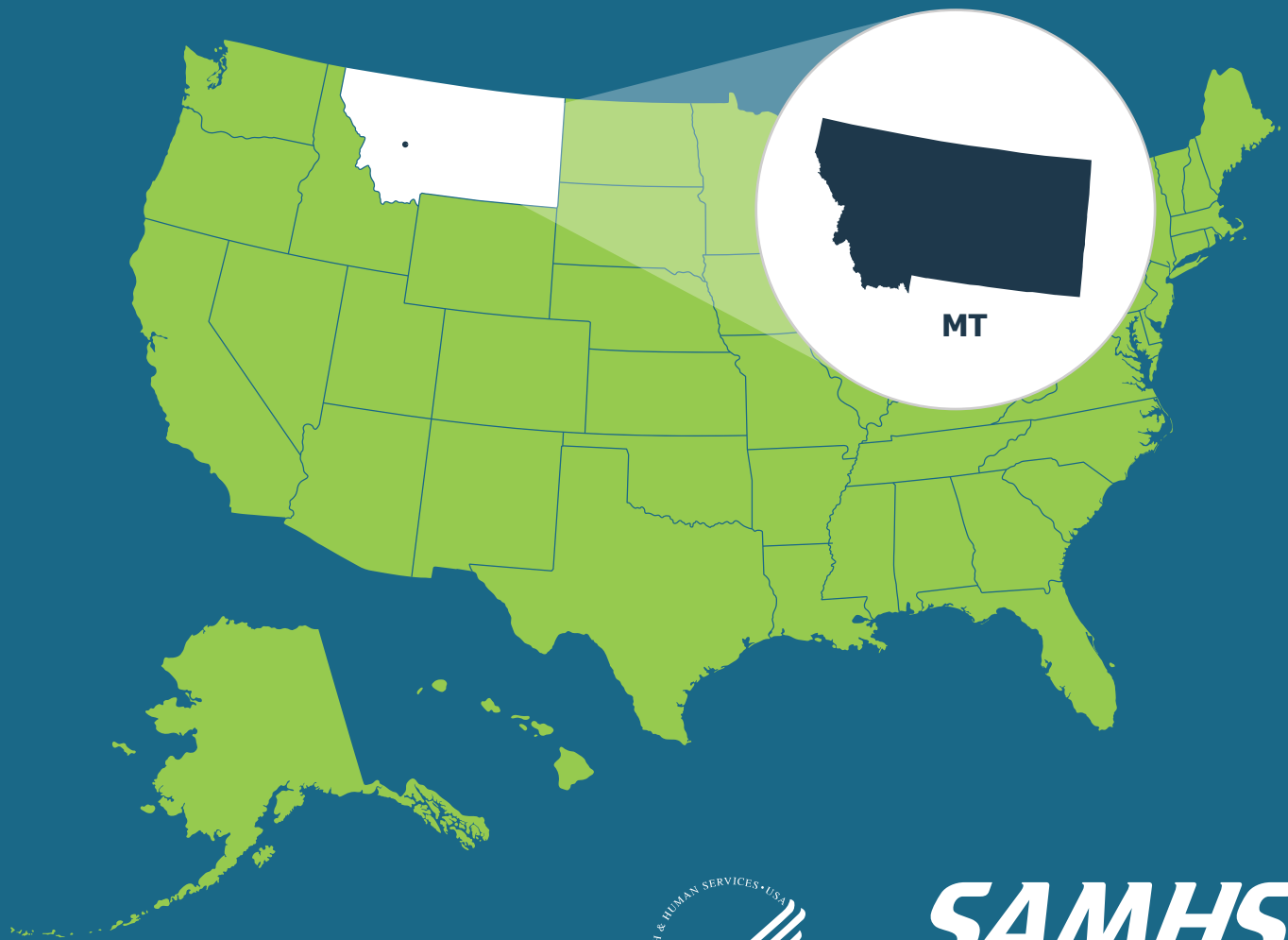
- Establish an updated charter/mission that aligns with State Health Improvement Plan and other behavioral health priorities.

- Update interagency data sharing agreements.
- Develop a State Epidemiology Profile for suicide and substance use, misuse, abuse in MT.
- Develop indicators for county, regional, and state public and behavioral health planning for MH/SUD prevention, treatment, and recovery support.
- Continue monitoring, improving, and expanding state and local data tracking systems.
- Providing ongoing technical assistance and support to ensure data is understood and utilized effectively to educate community and state policy leaders.

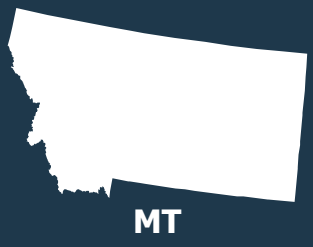
Behavioral Health **Barometer**

Montana, Volume 6

Indicators as measured through the 2019 National Survey on Drug Use and Health
and the National Survey of Substance Abuse Treatment Services



SAMHSA
Substance Abuse and Mental Health Services Administration



Acknowledgments

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Originating Office

Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

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HHS Publication No. SMA–20–Baro–19–MT
Published 2020

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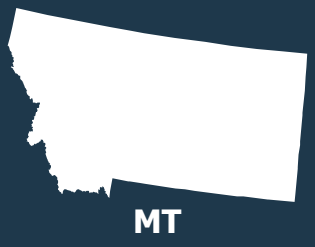

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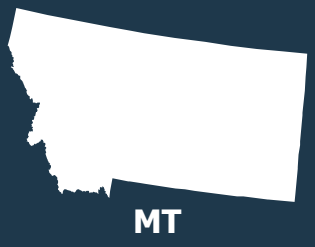
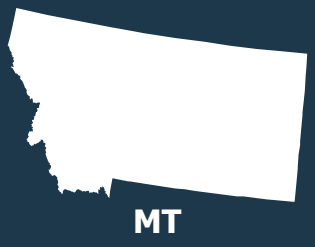


Foreword



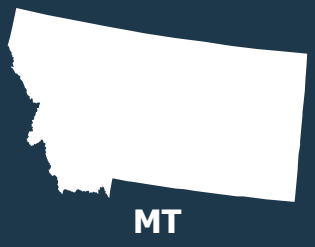
The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), is charged with reducing the impact of substance abuse and mental illness on America's communities. SAMHSA is pursuing this mission at a time of significant change.

The *Behavioral Health Barometer: Montana, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services* is one of a series of national, regional, and state reports that provide a snapshot of behavioral health in the United States. The reports present a set of substance use and mental health indicators as measured through the National Survey on Drug Use and Health (NSDUH) and the National Survey of Substance Abuse Treatment Services (N–SSATS), sponsored by SAMHSA.

This array of indicators provides a unique overview of the nation's behavioral health at a point in time as well as a mechanism for tracking changes over time. Behavioral Health Barometers for the nation, 10 regions, and all 50 states and the District of Columbia are published as part of SAMHSA's behavioral health quality improvement approach. Most importantly, the Behavioral Health Barometers provide critical information in support of SAMHSA's mission of reducing the impact of substance abuse and mental illness on America's communities.

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Introduction



Purpose of This Report

Behavioral Health Barometer: Montana, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services provides an annual update on a series of topics that focus on substance use and mental health (collectively referred to as *behavioral health*) in the United States. SAMHSA selected specific topics and indicators in this report to represent a cross-section of the key behavioral health indicators that are assessed in SAMHSA data collections, including NSDUH and N–SSATS. This report is intended to provide a concise, reader-friendly summary of key behavioral health measures for lay and professional audiences.

Organization of This Report

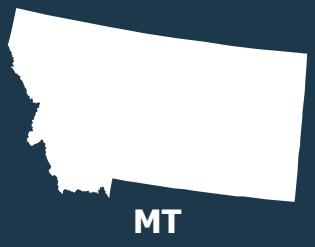
This report is divided into sections based on content areas and age groups. It begins with sections on substance use, mental health, and mental health treatment among youth aged 12–17, followed by a section on substance use and mental health among young adults aged 18–25. Next are sections on substance use, misuse, use disorders, and treatment among youth and adults combined and on mental health and treatment among adults aged 18 or older. Figure titles are included above all graphics, including callouts for figure notes that are presented on pages 34–35. These figure notes include additional information about the measures, populations, and analyses presented in the graphics and text. Definitions of key measures and terms included in the report are presented on pages 36–37.

Methodological Information

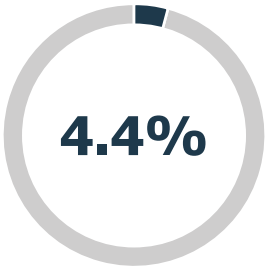
Statistical tests (t-tests) have been conducted for all statements appearing in the text of the report based on NSDUH data that compare estimates between years or population subgroups. These tests properly account for the variances of each estimate being tested, as well as any joint variability (covariance) due to sample design or among non-mutually exclusive groups (e.g., each state is a subgroup of its respective region, and each region is a subgroup of the total United States). Positive covariance reduces the overall variance of the test statistic and may produce statistically significant results, even when the confidence intervals of each estimate overlap. Unless explicitly stated that a difference is not statistically significant, all statements based on NSDUH data that describe differences are significant at the .05 level. Standard NSDUH suppression rules have been applied for all NSDUH estimates in this report. Pages 27–30 present N–SSATS data, and because N–SSATS provides counts of people enrolled at all treatment facilities (as opposed to providing estimates based on a sample of treatment facilities), conducting significance tests is not necessary. Tables that display all data points included in this report, including tests of statistical significance and standard errors, are available upon request. To request these tables or to ask any questions regarding how to use or interpret the data included in this report, please contact CBHSQRequest@samhsa.hhs.gov.

Youth Substance Use

Cigarette Use

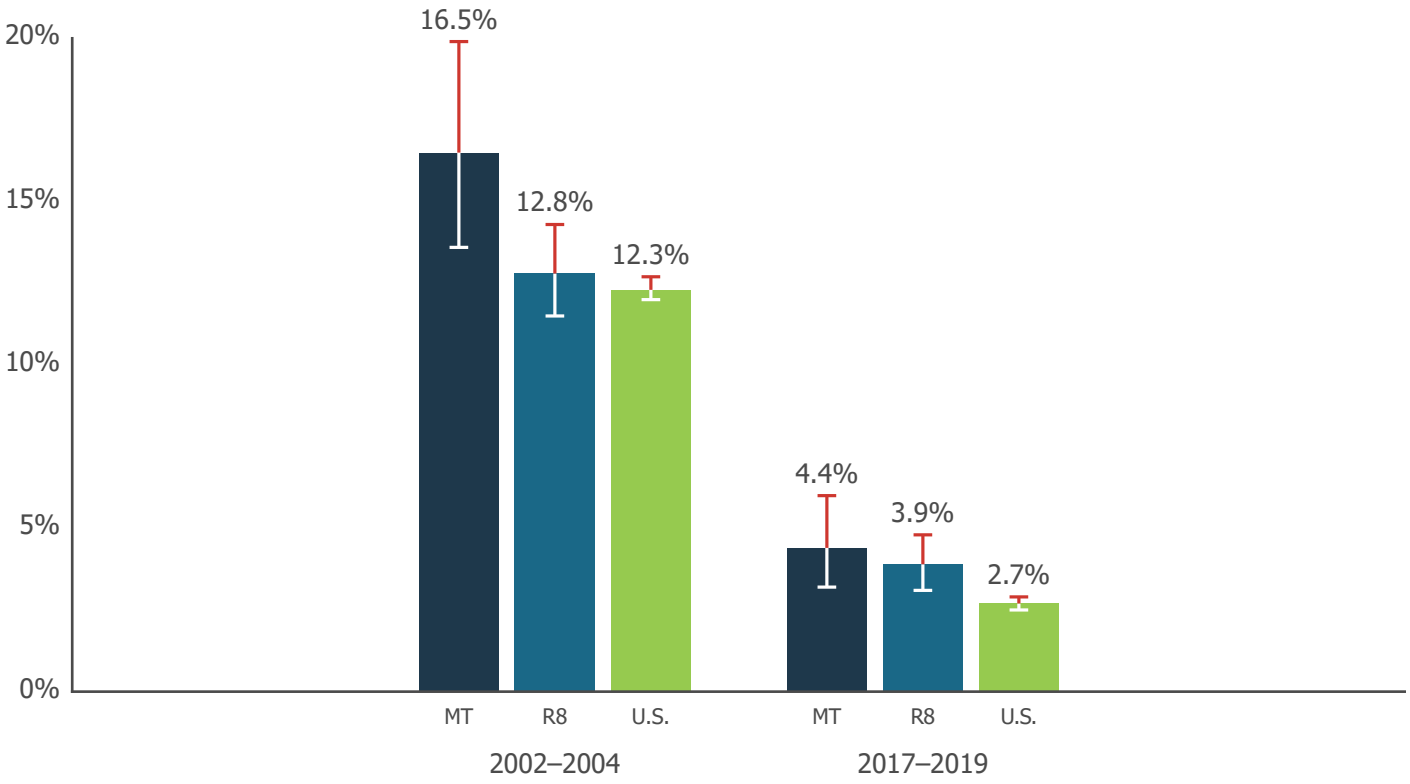


Changes in Past-Month Cigarette Use among Youth Aged 12–17 in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among youth aged 12–17 in Montana, the annual average percentage of cigarette use in the past month decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month cigarette use in Montana was **4.4%** (or **3,000**), similar to the regional average (**3.9%**) but higher than the national average (**2.7%**).

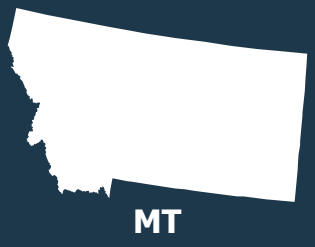


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Youth Substance Use

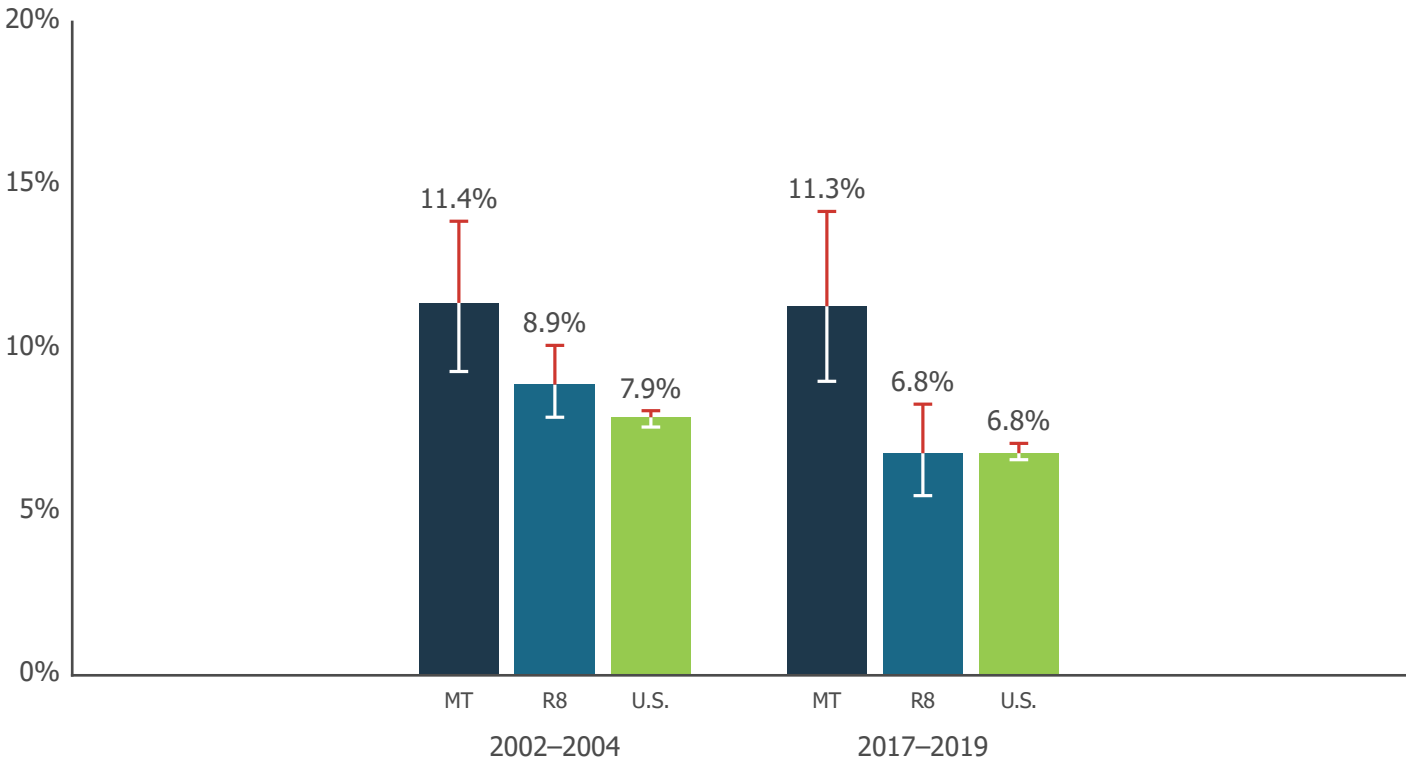
Marijuana Use



Changes in Past-Month Marijuana Use among Youth Aged 12–17 in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among youth aged 12–17 in Montana, the annual average percentage of marijuana use in the past month did not significantly change between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month marijuana use in Montana was **11.3%** (or **9,000**), higher than both the regional average (**6.8%**) and the national average (**6.8%**).

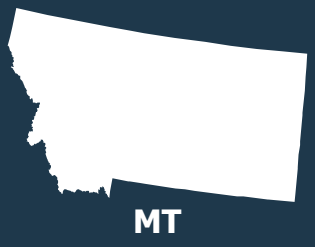


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

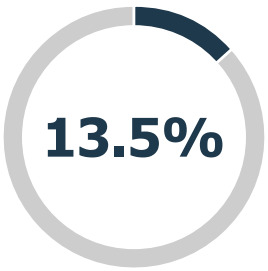
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Youth Substance Use

Alcohol Use

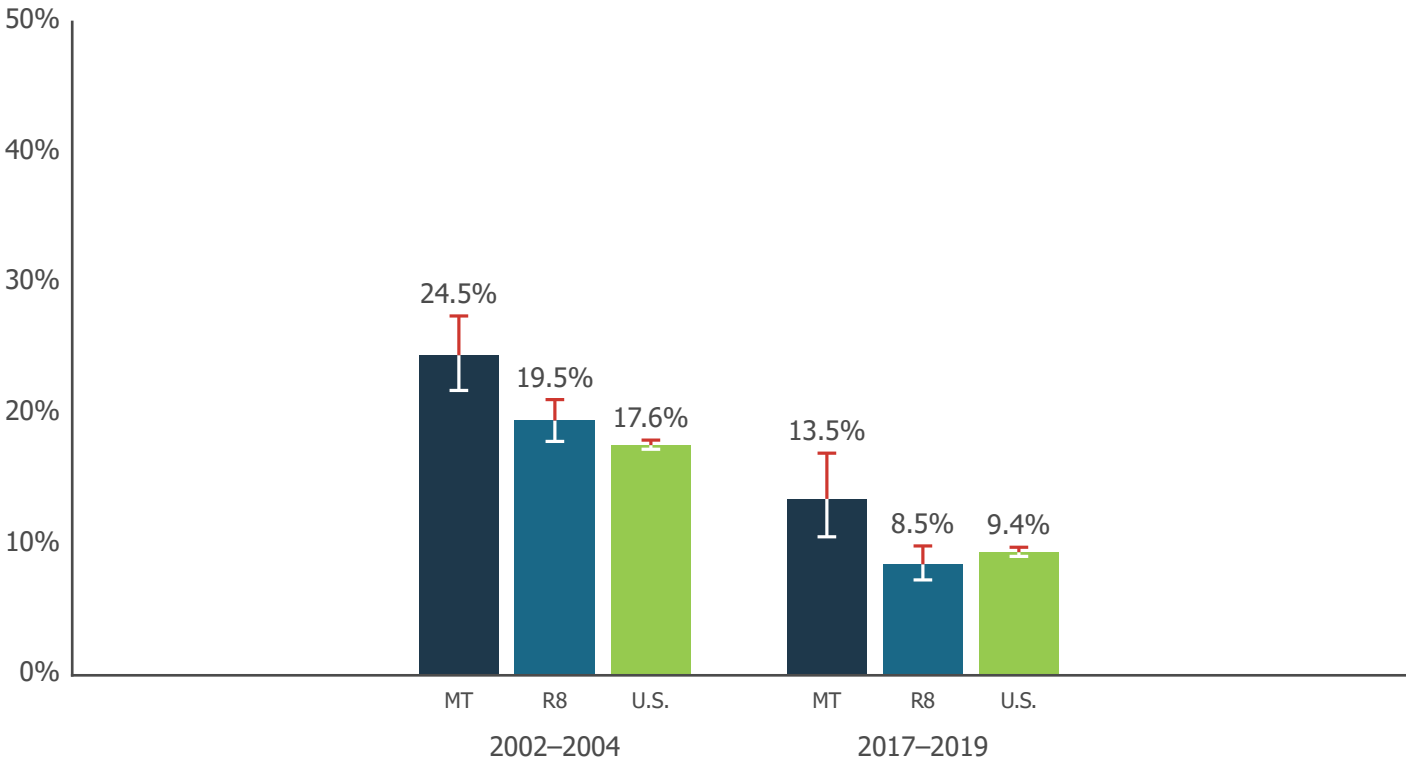


Changes in Past-Month Alcohol Use among Youth Aged 12–17 in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among youth aged 12–17 in Montana, the annual average percentage of alcohol use in the past month decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month alcohol use in Montana was **13.5%** (or **10,000**), higher than both the regional average (**8.5%**) and the national average (**9.4%**).

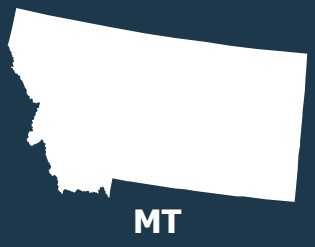


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

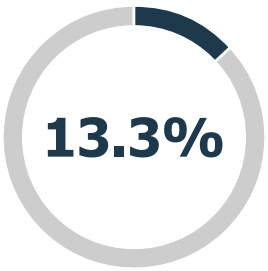
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Youth Substance Use

Illicit Drug Use

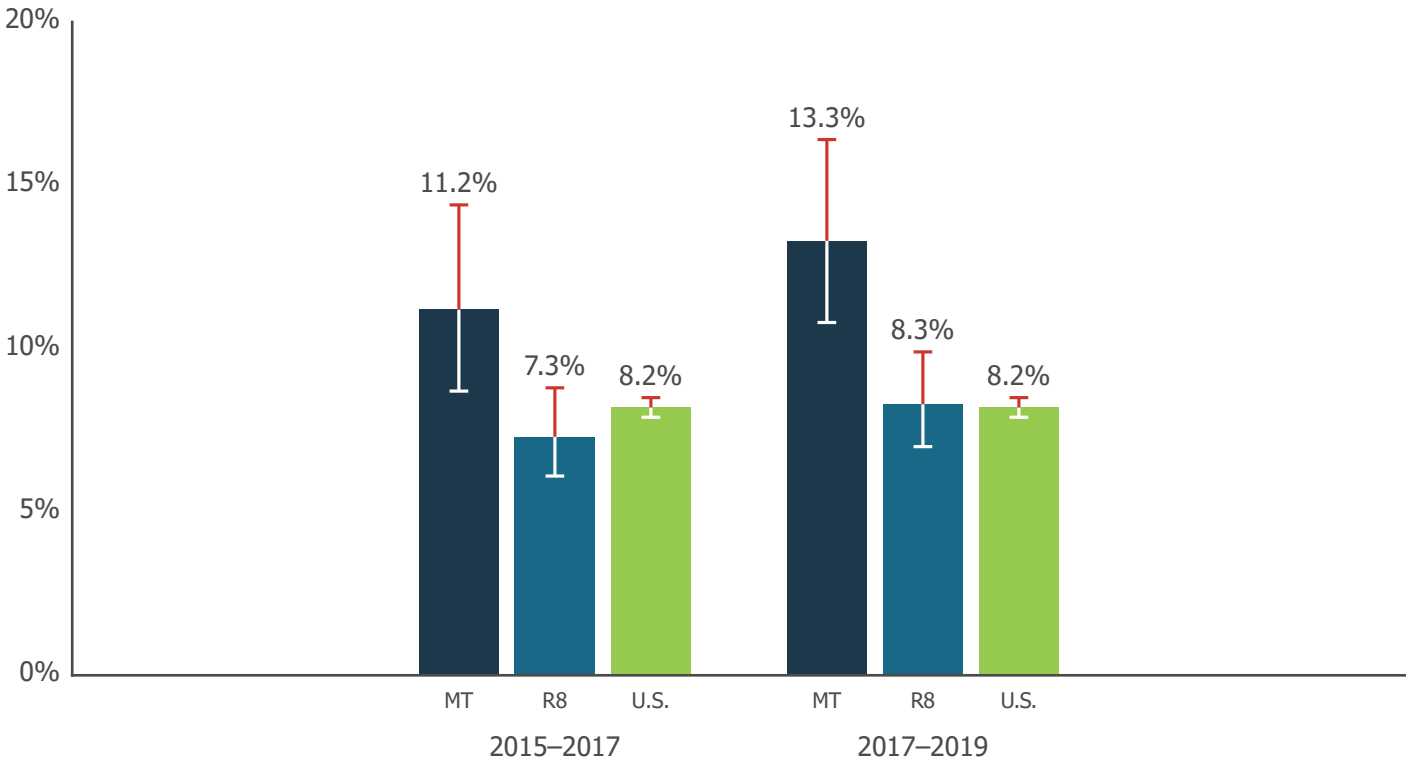


Changes in Past-Month Illicit Drug Use among Youth Aged 12–17 in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]



Among youth aged 12–17 in Montana, the annual average percentage of illicit drug use in the past month did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month illicit drug use in Montana was **13.3%** (or **10,000**), higher than both the regional average (**8.3%**) and the national average (**8.2%**).

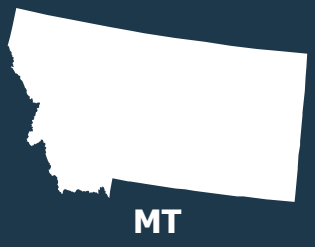


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Youth Substance Use

Initiation of Substance Use

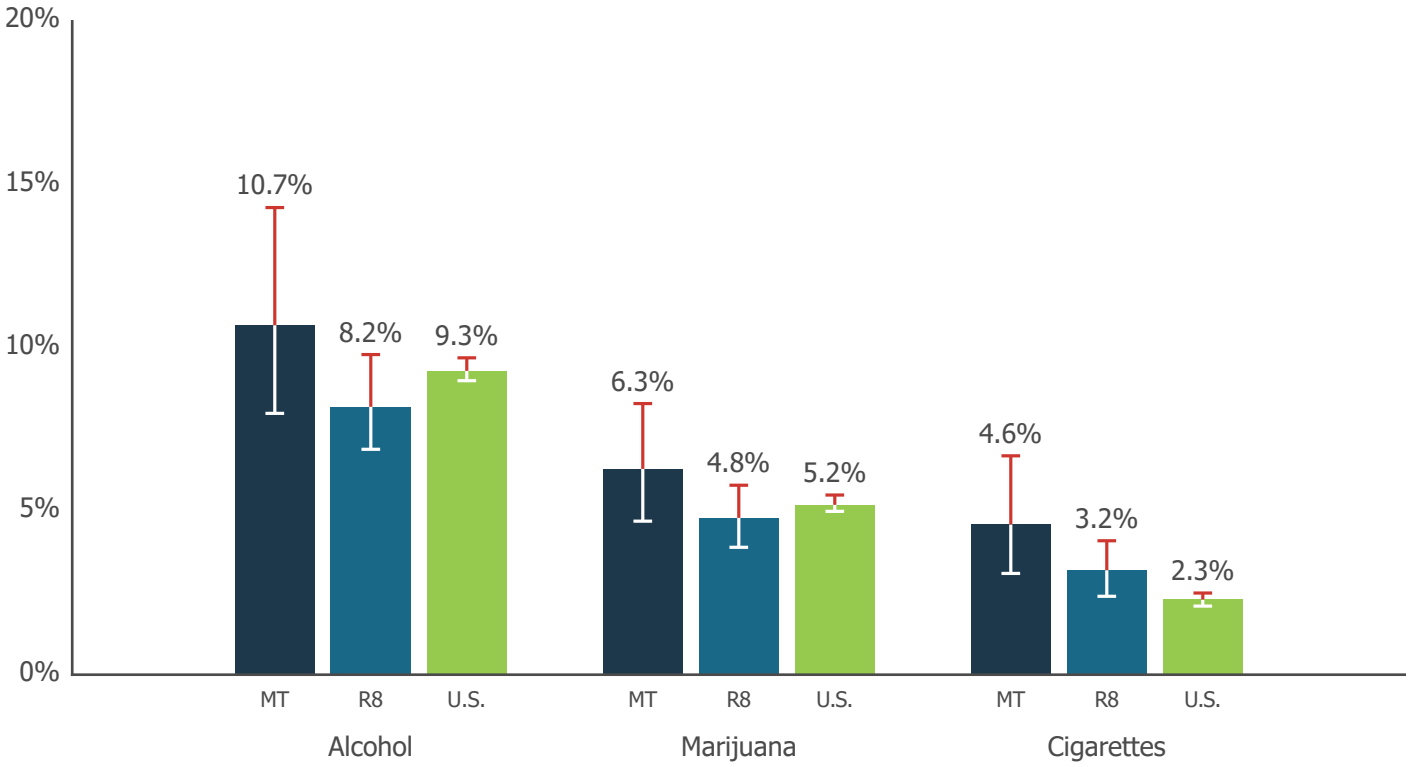


Past-Year Initiation (First Lifetime Use) of Selected Substances among Youth Aged 12–17 in Montana, Region 8, and the United States (Annual Average, 2017–2019)[1]

Among youth aged 12–17 in Montana, during 2017–2019, an annual average of **10.7%** (or **8,000**) used alcohol for the first time in their lives, similar to both the regional average (**8.2%**) and the national average (**9.3%**).

In Montana, an annual average of **6.3%** (or **5,000**) used marijuana for the first time in their lives, similar to both the regional average (**4.8%**) and the national average (**5.2%**).

In Montana, an annual average of **4.6%** (or **3,000**) used cigarettes for the first time in their lives, similar to the regional average (**3.2%**) but higher than the national average (**2.3%**).

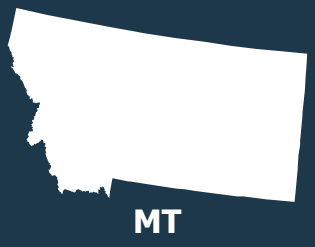


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

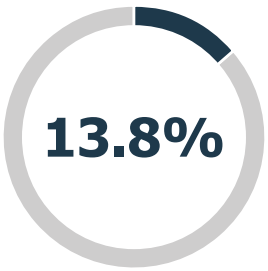
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017–2019.

Youth Mental Health and Service Use

Depression

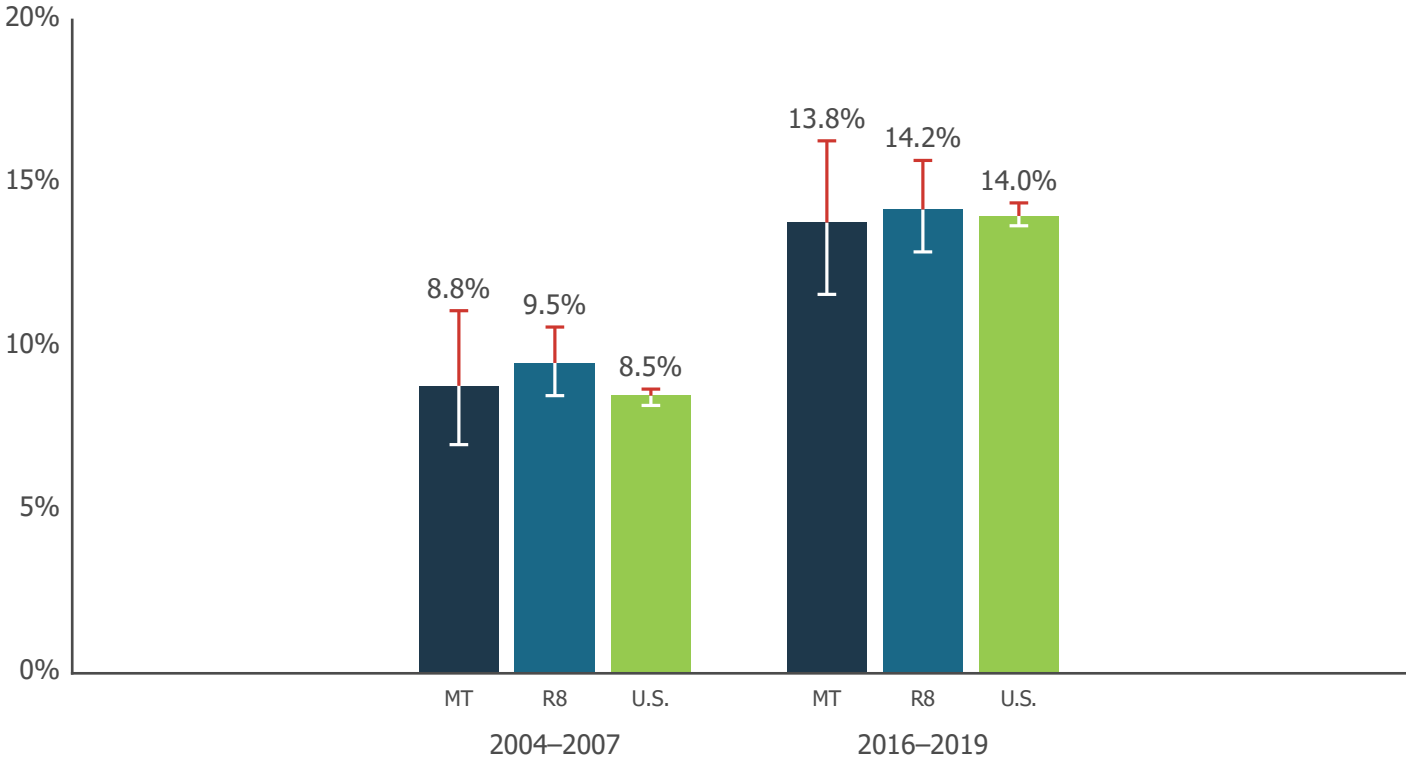


Changes in Past-Year Major Depressive Episode (MDE) among Youth Aged 12–17 in Montana, Region 8, and the United States (Annual Averages, 2004–2007 and 2016–2019)[1,2]



Among youth aged 12–17 in Montana, the annual average percentage with an MDE in the past year increased between 2004–2007 and 2016–2019.

During 2016–2019, the annual average prevalence of past-year MDE in Montana was **13.8%** (or **10,000**), similar to both the regional average (**14.2%**) and the national average (**14.0%**).

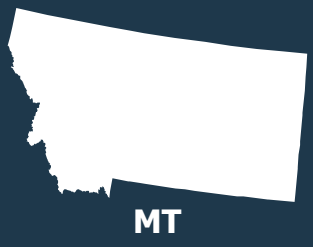


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

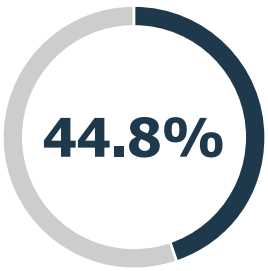
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004–2007 and 2016–2019.

Youth Mental Health and Service Use

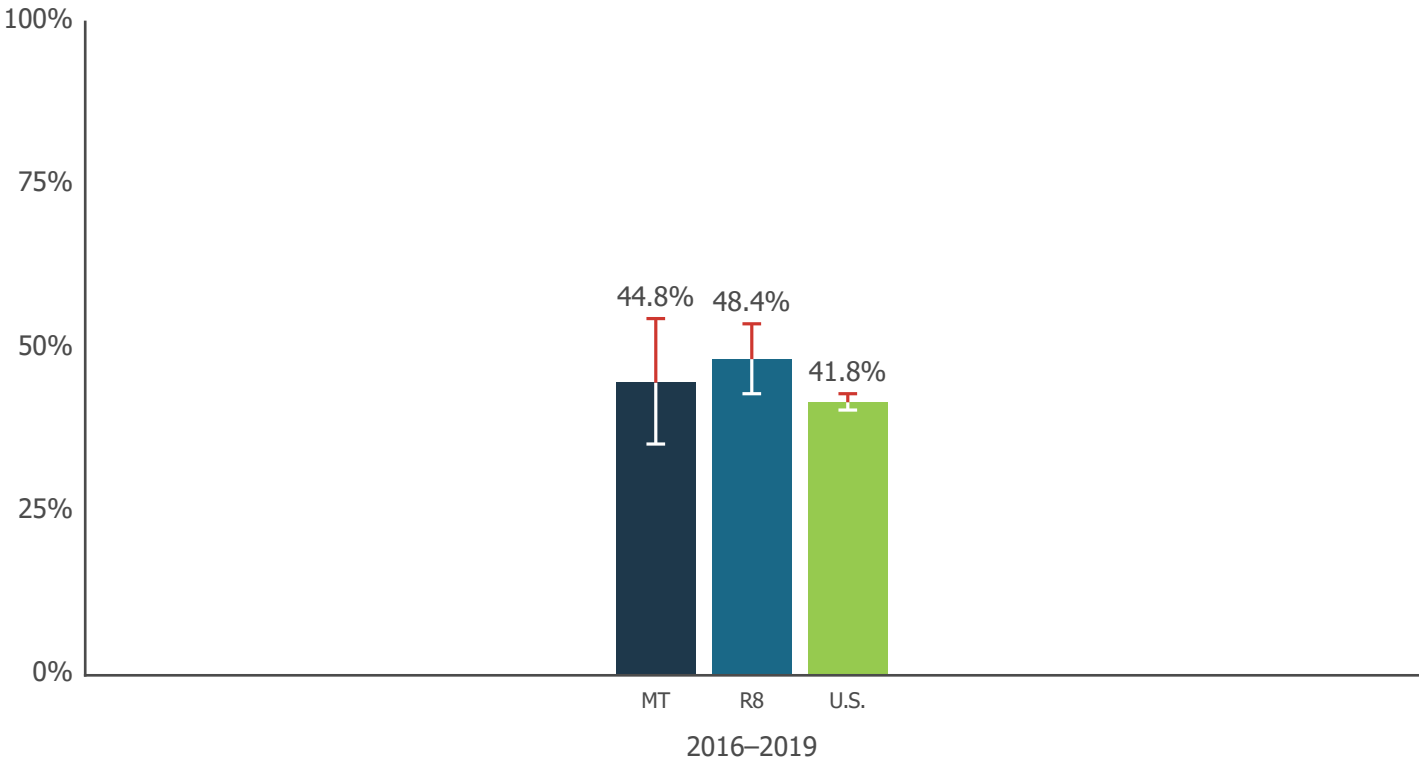
Depression Care



Past-Year Depression Care among Youth Aged 12–17 with Major Depressive Episode (MDE) in Montana, Region 8, and the United States (Annual Average, 2016–2019)[1,3]



Among youth aged 12–17 in Montana during 2016–2019 with an MDE in the past year, an annual average of **44.8%** (or **5,000**) received depression care in the past year, similar to both the regional average (**48.4%**) and the national average (**41.8%**).



Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016–2019.

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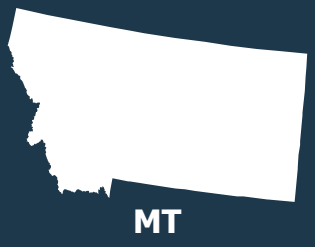
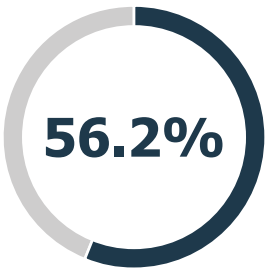
Young Adult Substance Use and Use Disorders

Tobacco Use

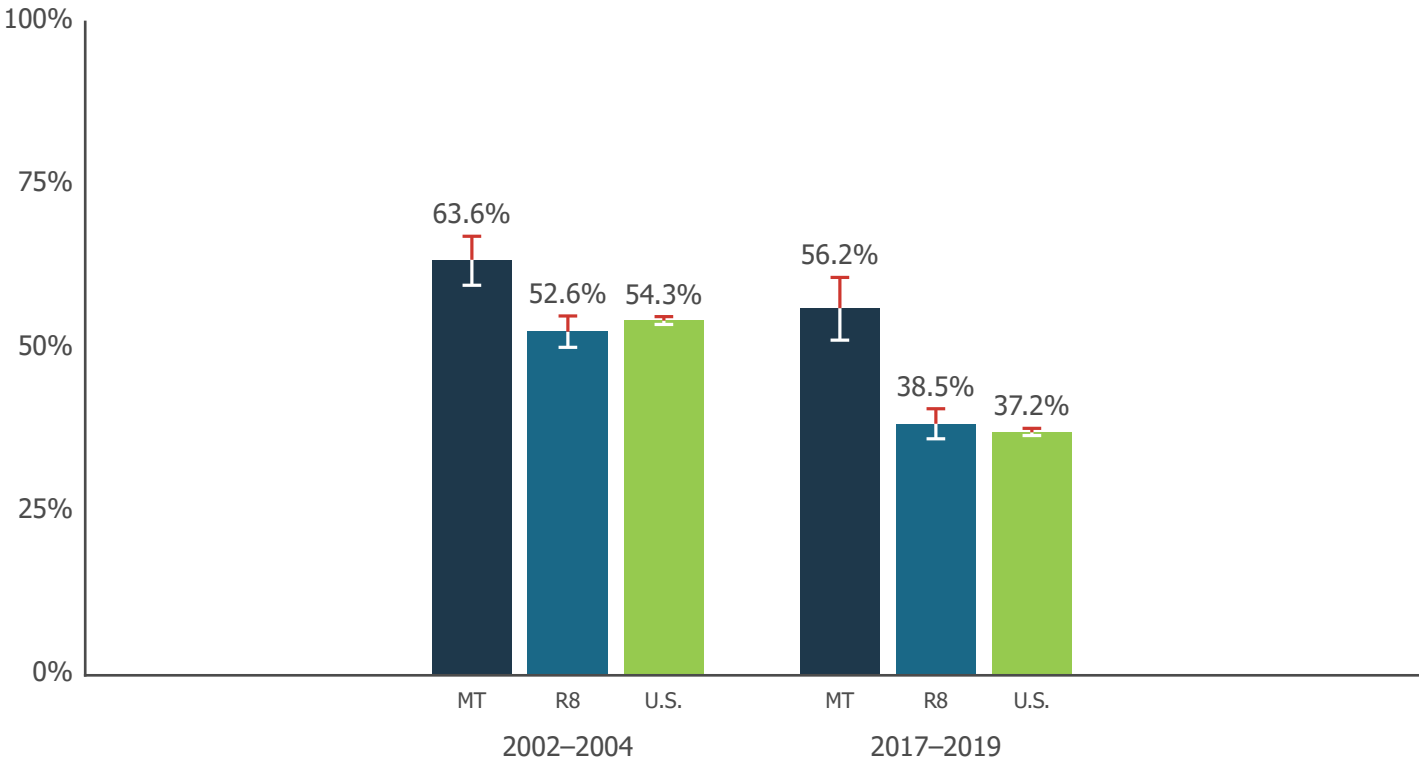


Changes in Past-Year Tobacco Use among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among young adults aged 18–25 in Montana, the annual average percentage of tobacco use in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year tobacco use in Montana was **56.2%** (or **62,000**), higher than both the regional average (**38.5%**) and the national average (**37.2%**).

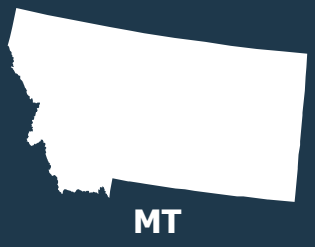


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

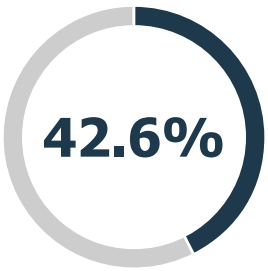
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Young Adult Substance Use and Use Disorders

Marijuana Use

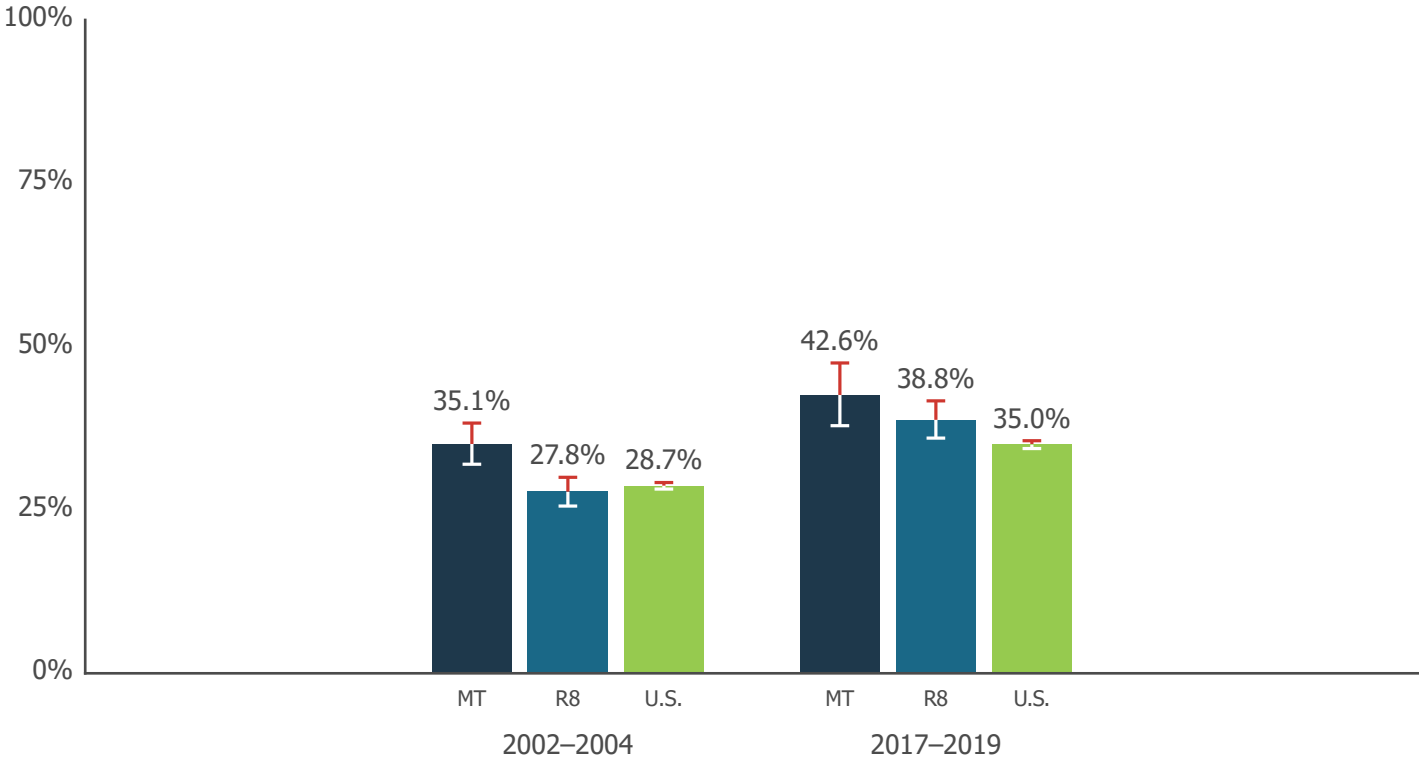


Changes in Past-Year Marijuana Use among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among young adults aged 18–25 in Montana, the annual average percentage of marijuana use in the past year increased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year marijuana use in Montana was **42.6%** (or **47,000**), similar to the regional average (**38.8%**) but higher than the national average (**35.0%**).

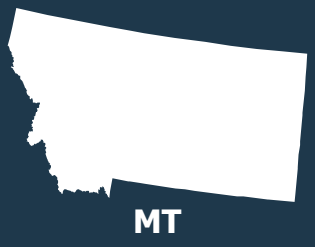


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Young Adult Substance Use and Use Disorders

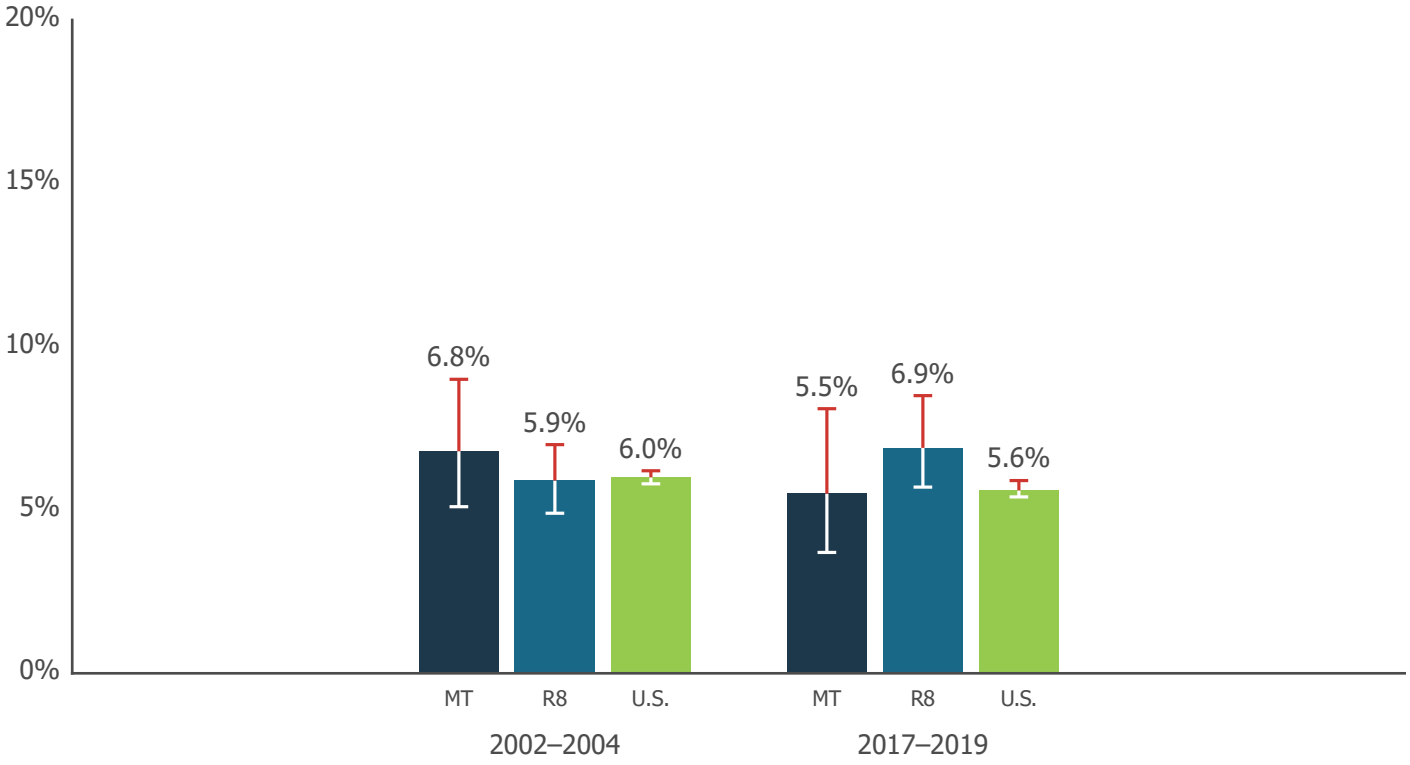
Marijuana Use Disorder



Changes in Past-Year Marijuana Use Disorder among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among young adults aged 18–25 in Montana, the annual average percentage of marijuana use disorder in the past year did not significantly change between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year marijuana use disorder in Montana was **5.5%** (or **6,000**), similar to both the regional average (**6.9%**) and the national average (**5.6%**).

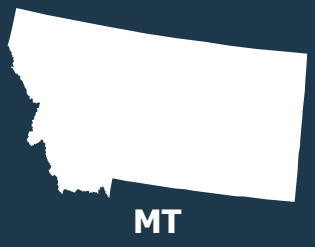


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Young Adult Substance Use and Use Disorders

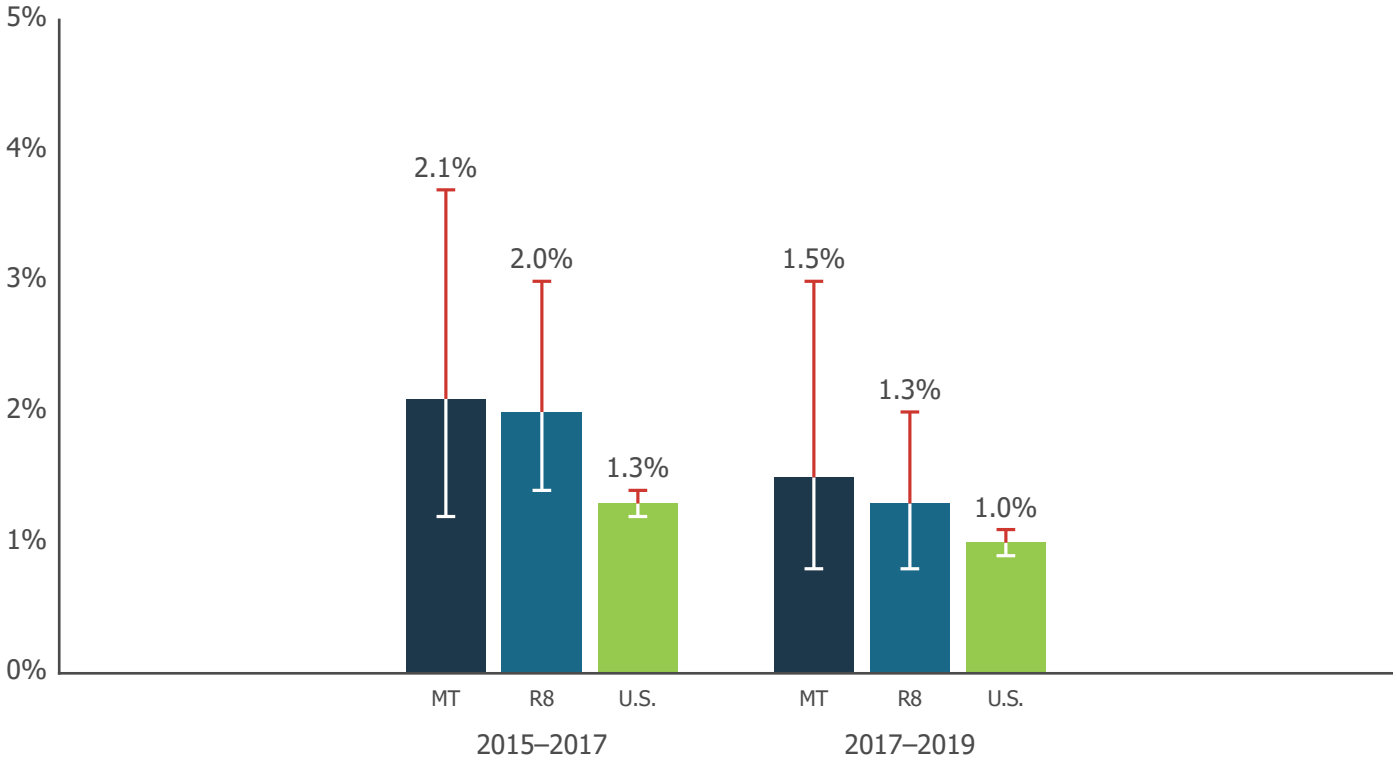
Opioid Use Disorder



Changes in Past-Year Opioid Use Disorder among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]

Among young adults aged 18–25 in Montana, the annual average percentage of opioid use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year opioid use disorder in Montana was **1.5%** (or **2,000**), similar to both the regional average (**1.3%**) and the national average (**1.0%**).

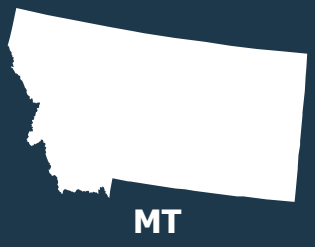


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

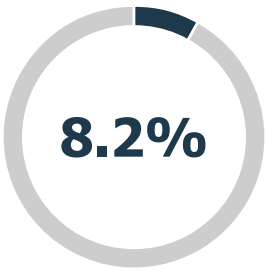
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Young Adult Substance Use and Use Disorders

Illicit Drug Use Disorder

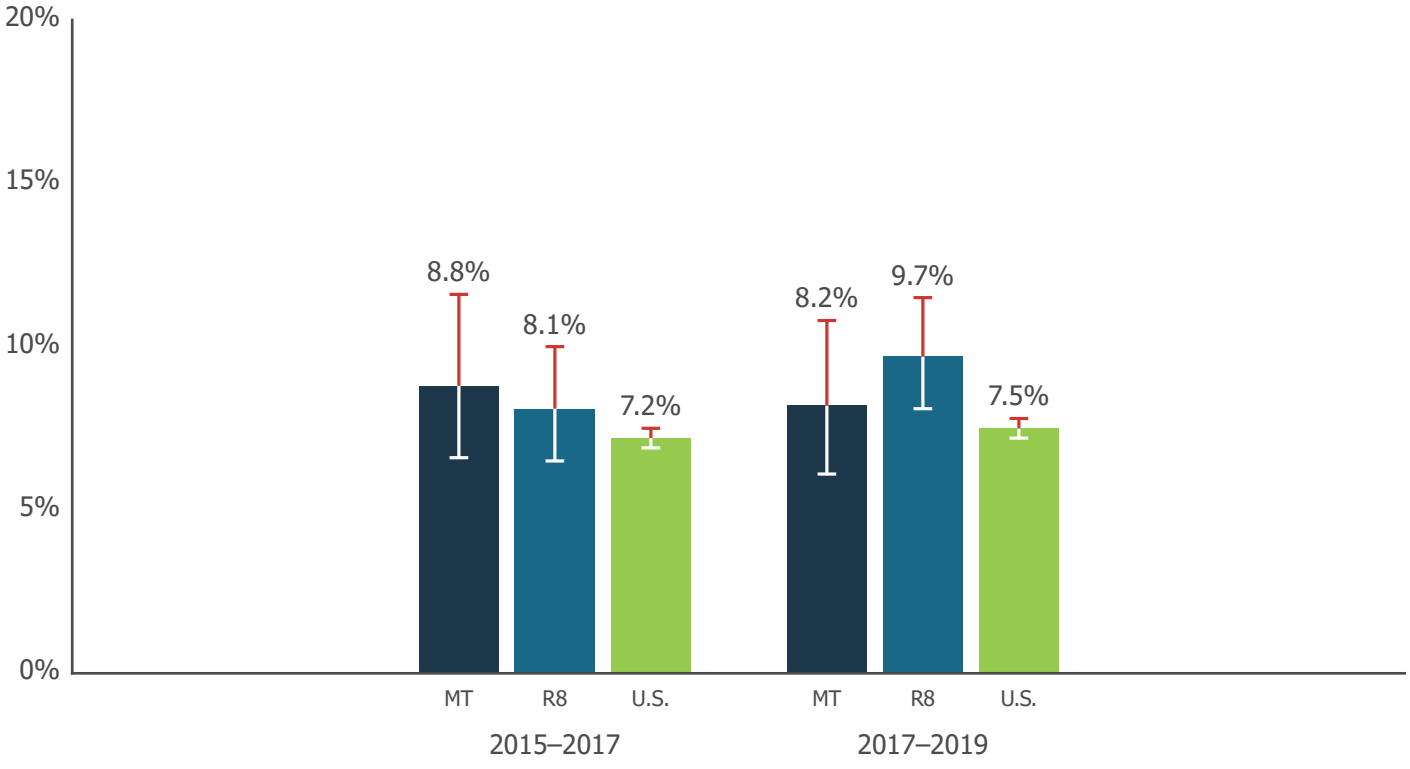


Changes in Past-Year Illicit Drug Use Disorder among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]



Among young adults aged 18–25 in Montana, the annual average percentage of illicit drug use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year illicit drug use disorder in Montana was **8.2%** (or **9,000**), similar to both the regional average (**9.7%**) and the national average (**7.5%**).

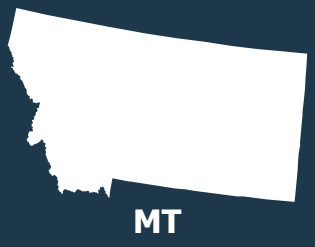


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

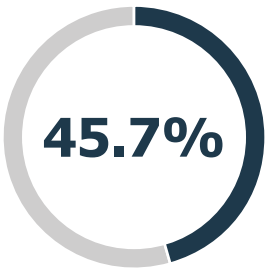
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Young Adult Substance Use and Use Disorders

Binge Alcohol Use

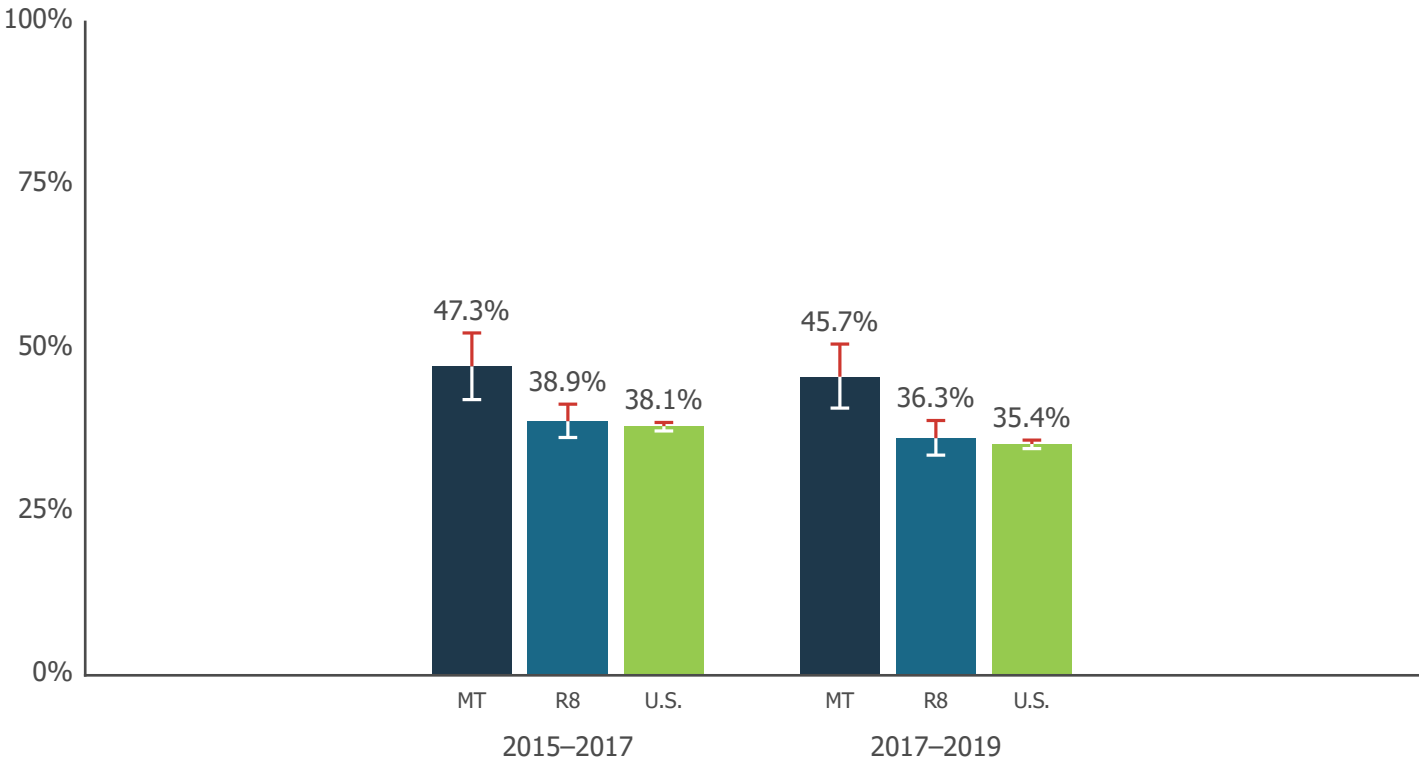


Changes in Past-Month Binge Alcohol Use among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1,4]



Among young adults aged 18–25 in Montana, the annual average percentage of binge alcohol use in the past month did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-month binge alcohol use in Montana was **45.7%** (or **50,000**), higher than both the regional average (**36.3%**) and the national average (**35.4%**).

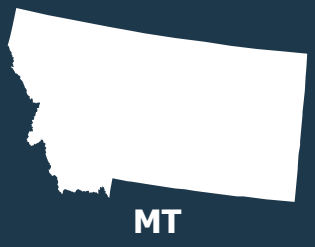


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Young Adult Substance Use and Use Disorders

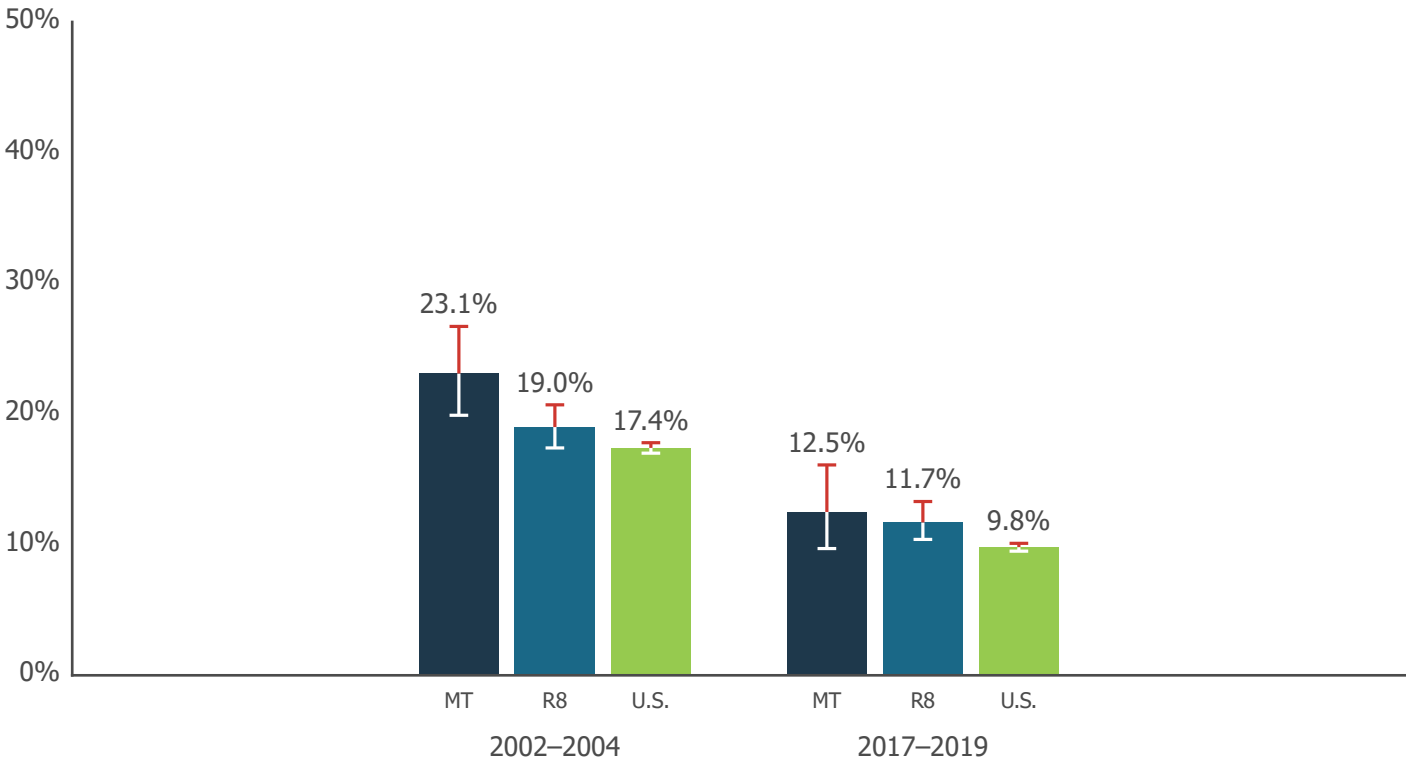
Alcohol Use Disorder



Changes in Past-Year Alcohol Use Disorder among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among young adults aged 18–25 in Montana, the annual average percentage of alcohol use disorder in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year alcohol use disorder in Montana was **12.5%** (or **14,000**), similar to both the regional average (**11.7%**) and the national average (**9.8%**).

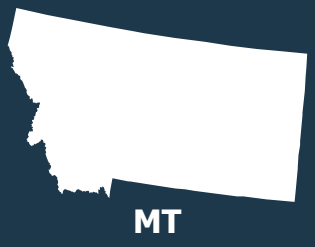


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

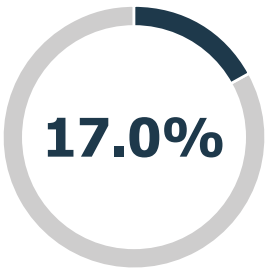
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Young Adult Substance Use and Use Disorders

Substance Use Disorder

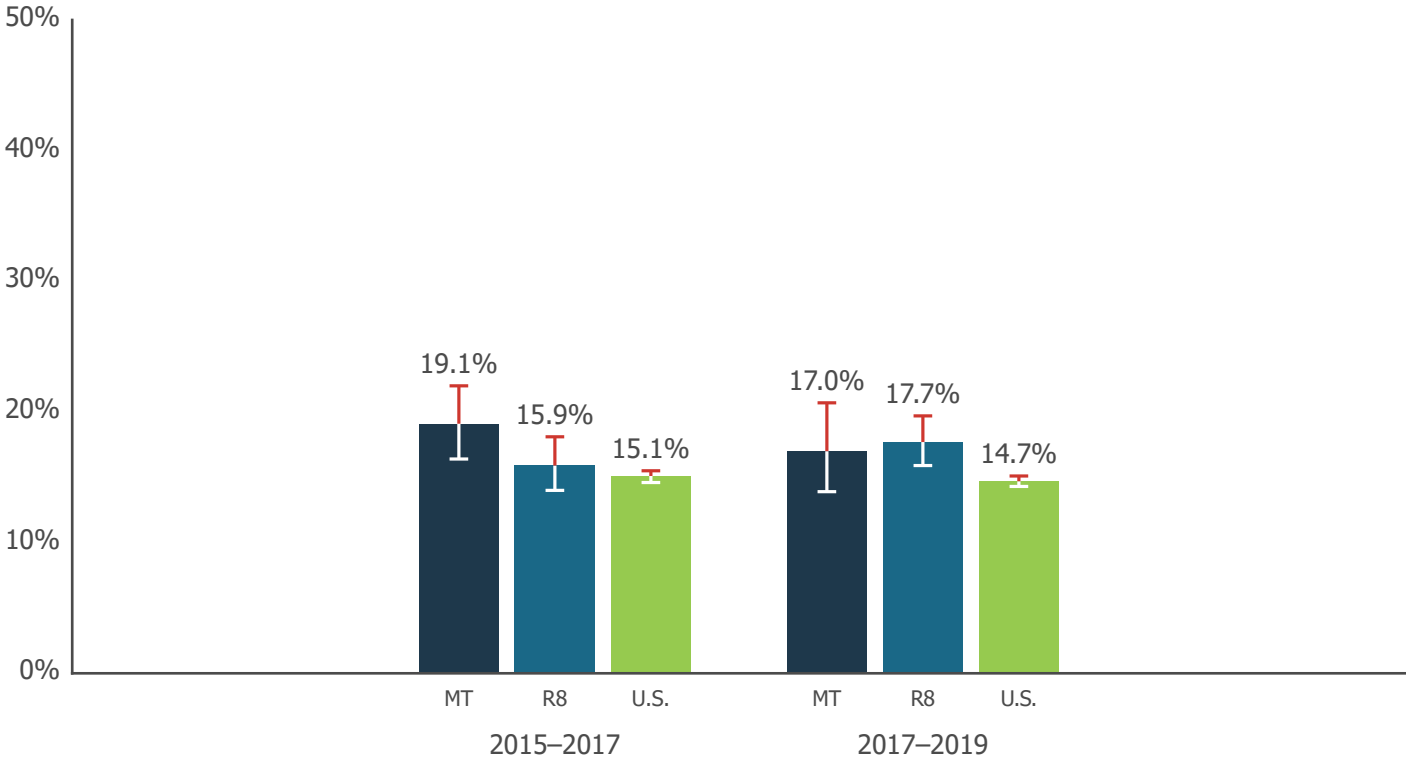


Changes in Past-Year Substance Use Disorder among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]



Among young adults aged 18–25 in Montana, the annual average percentage of substance use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year substance use disorder in Montana was **17.0%** (or **19,000**), similar to both the regional average (**17.7%**) and the national average (**14.7%**).

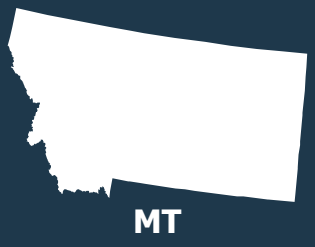


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Young Adult Mental Health

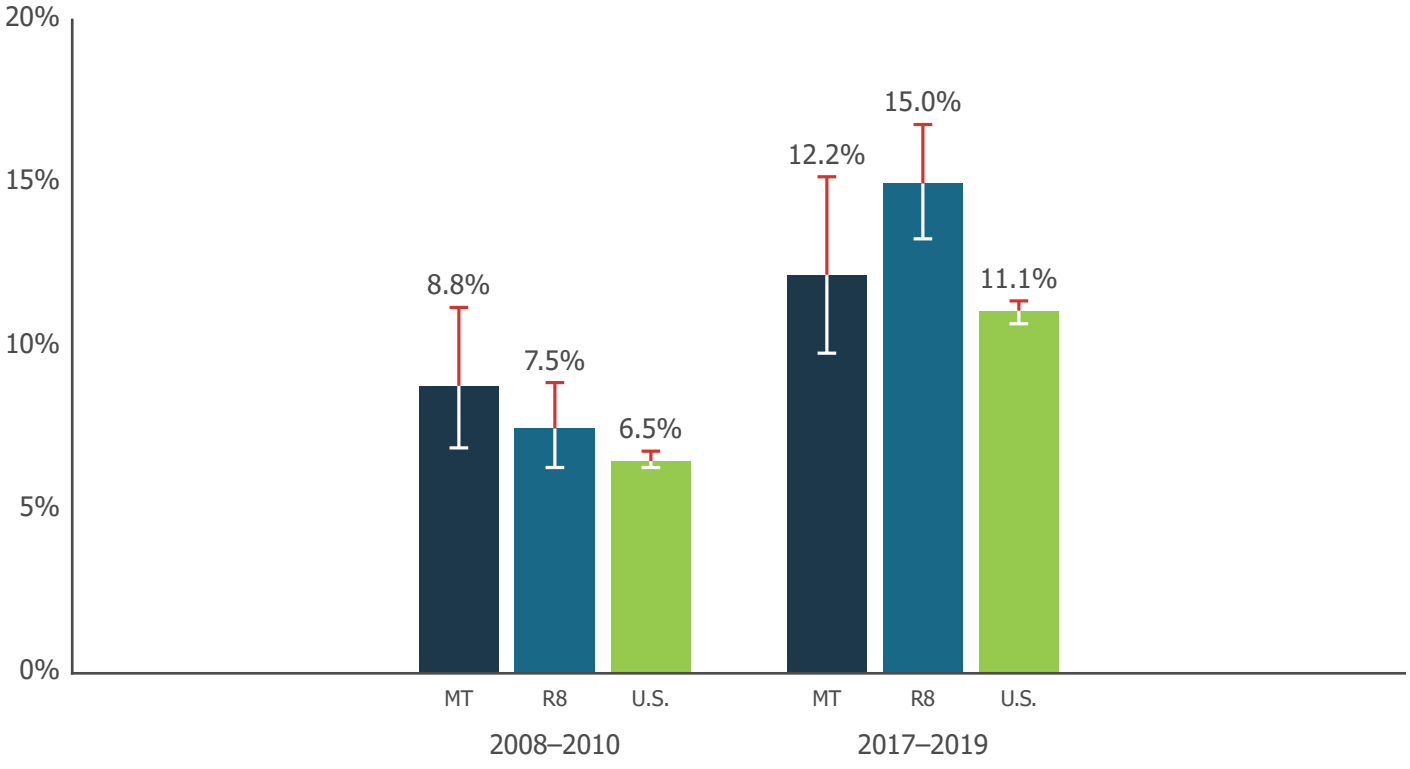
Serious Thoughts of Suicide



Changes in Past-Year Serious Thoughts of Suicide among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,5]

Among young adults aged 18–25 in Montana, the annual average percentage with serious thoughts of suicide in the past year did not significantly change between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year serious thoughts of suicide in Montana was **12.2%** (or **13,000**), similar to both the regional average (**15.0%**) and the national average (**11.1%**).



Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

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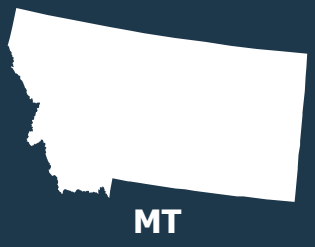
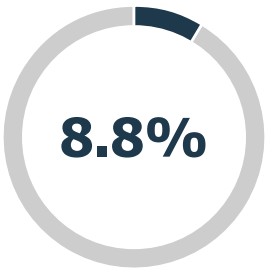
Young Adult Mental Health

Serious Mental Illness

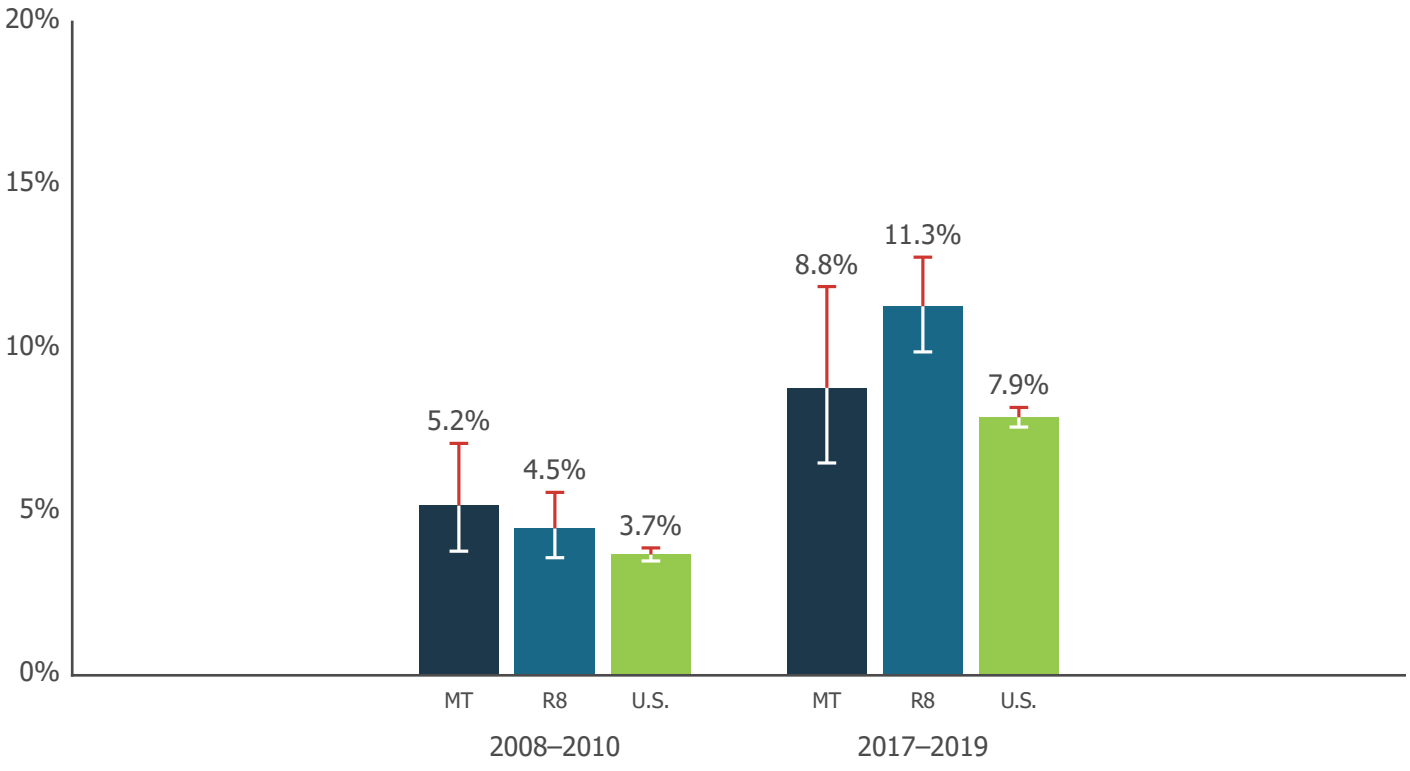


Changes in Past-Year Serious Mental Illness (SMI) among Young Adults Aged 18–25 in Montana, Region 8, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,6]



Among young adults aged 18–25 in Montana, the annual average percentage with SMI in the past year increased between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year SMI in Montana was **8.8%** (or **10,000**), similar to both the regional average (**11.3%**) and the national average (**7.9%**).

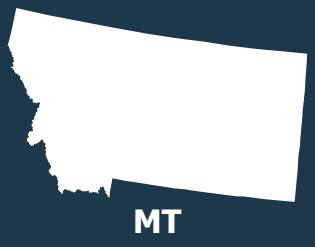


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

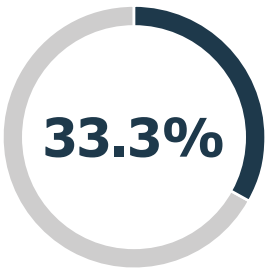
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Substance Use, Misuse, and Use Disorders

Tobacco Use

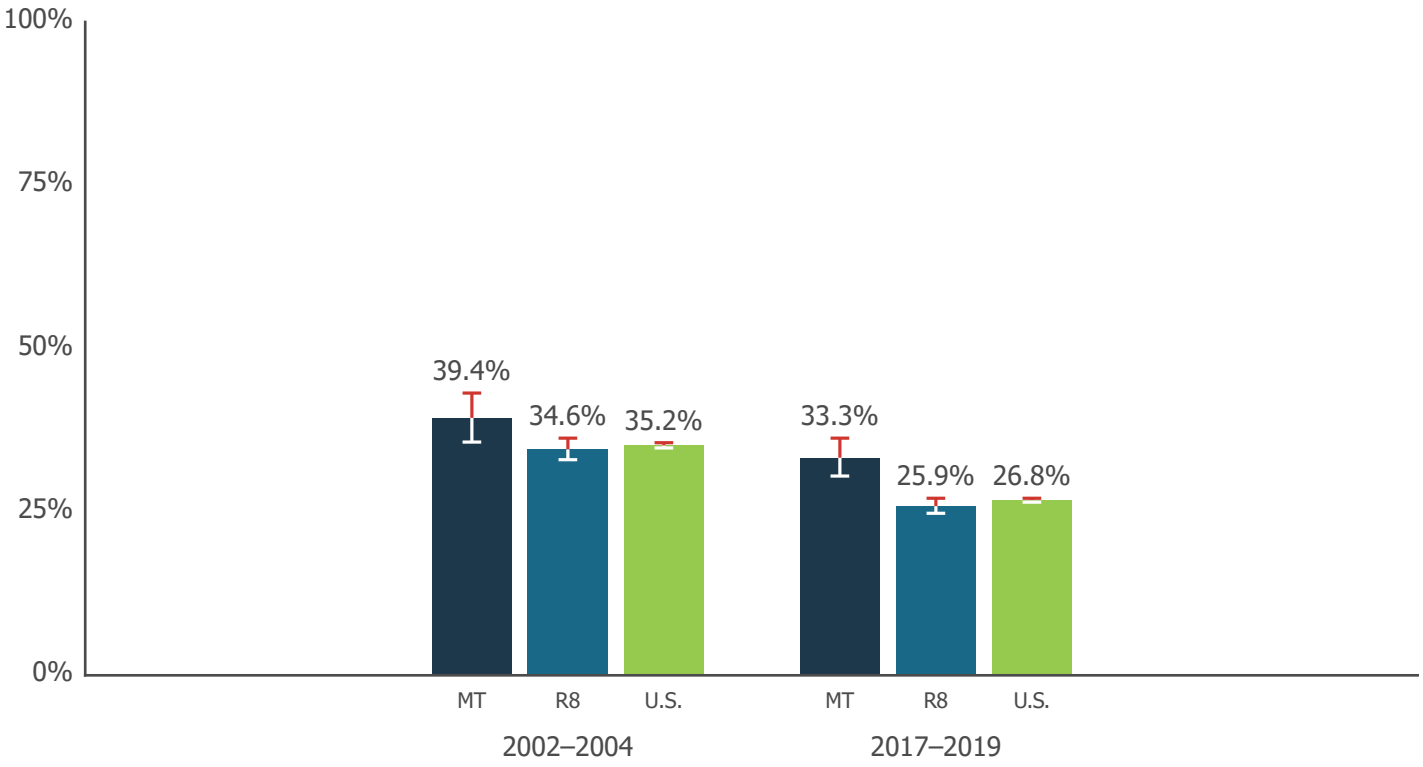


Changes in Past-Year Tobacco Use among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among people aged 12 or older in Montana, the annual average percentage of tobacco use in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year tobacco use in Montana was **33.3%** (or **298,000**), higher than both the regional average (**25.9%**) and the national average (**26.8%**).

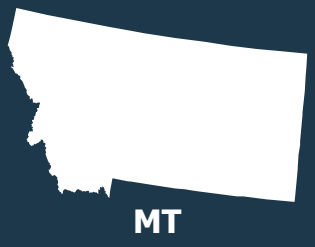


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

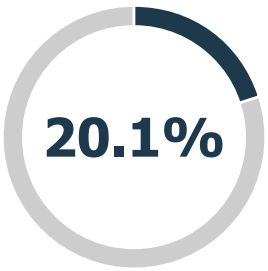
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Substance Use, Misuse, and Use Disorders

Marijuana Use

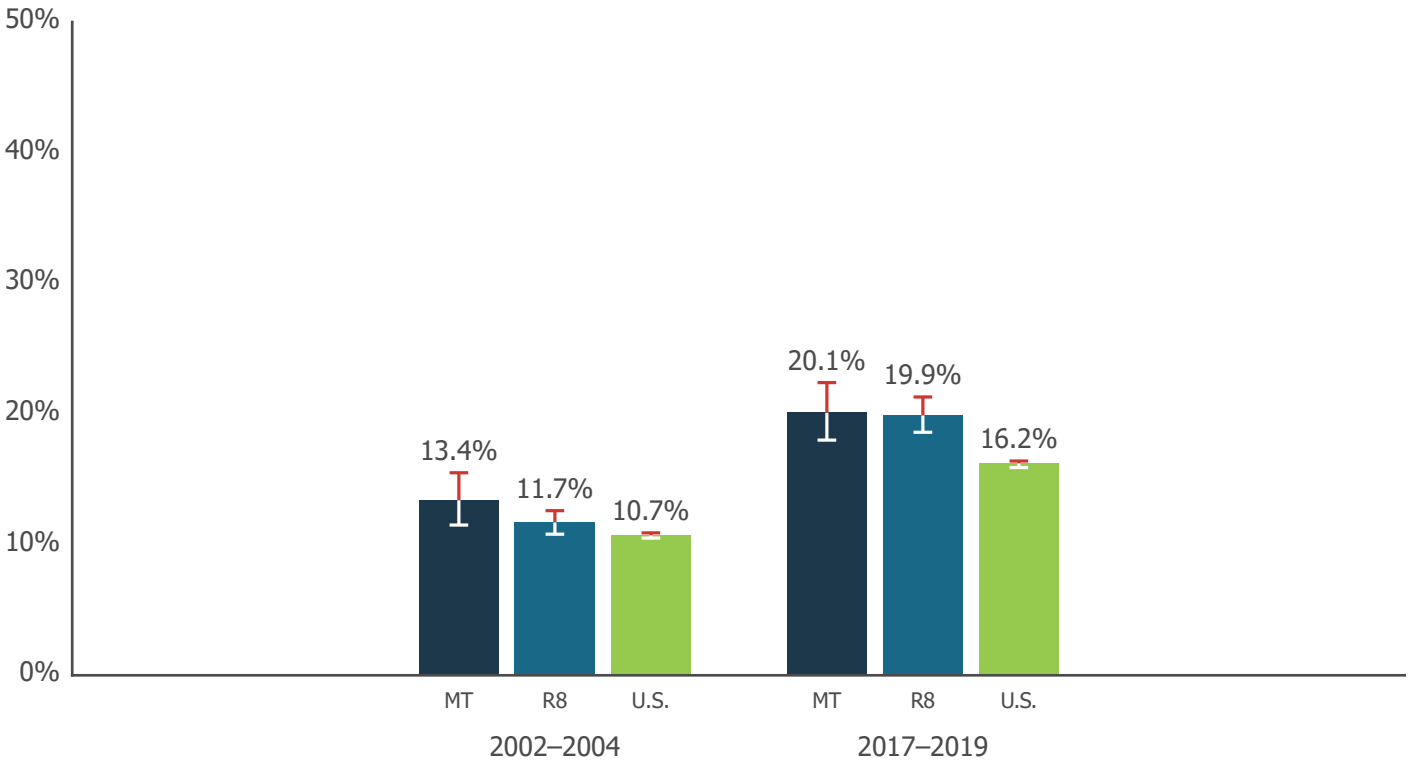


Changes in Past-Year Marijuana Use among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among people aged 12 or older in Montana, the annual average percentage of marijuana use in the past year increased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year marijuana use in Montana was **20.1%** (or **180,000**), similar to the regional average (**19.9%**) but higher than the national average (**16.2%**).

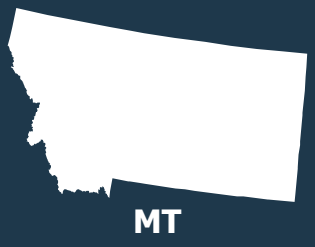


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Substance Use, Misuse, and Use Disorders

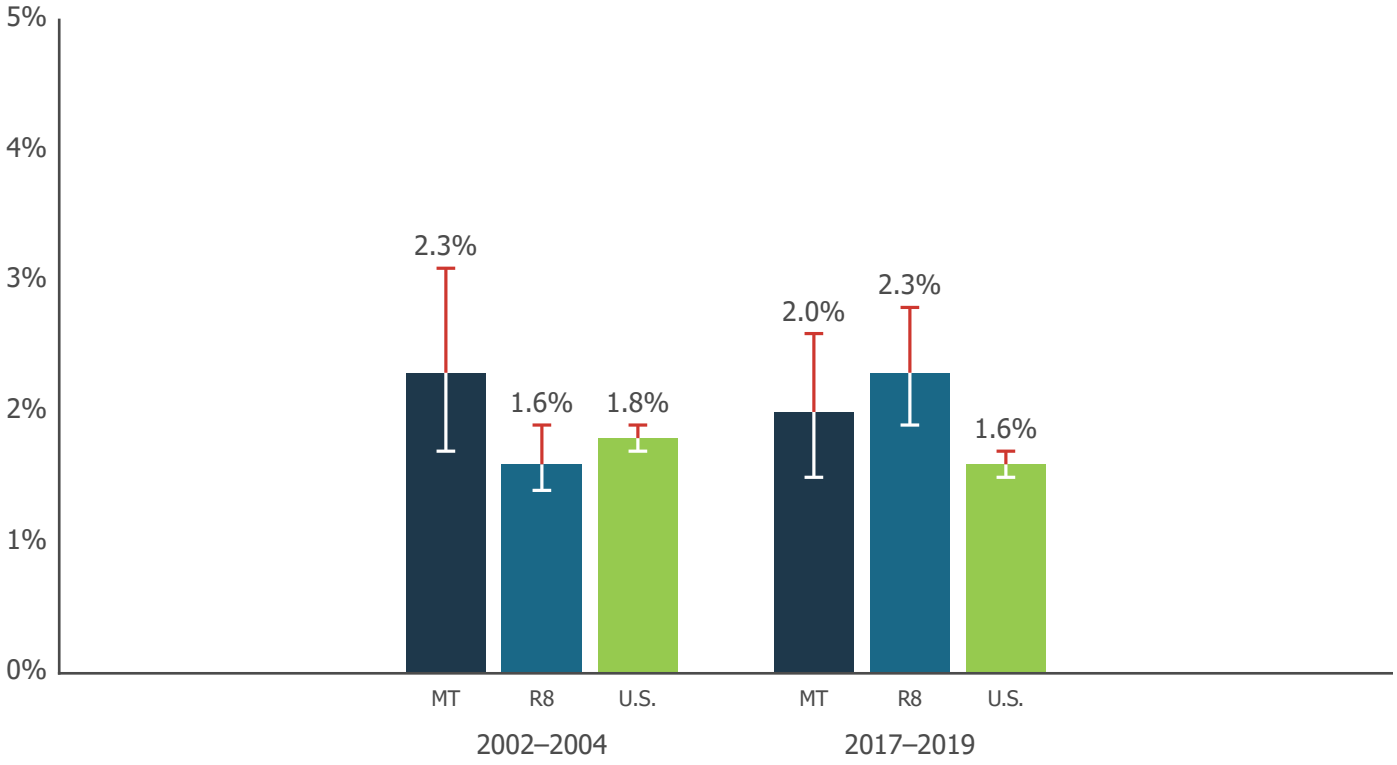
Marijuana Use Disorder



Changes in Past-Year Marijuana Use Disorder among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among people aged 12 or older in Montana, the annual average percentage of marijuana use disorder in the past year did not significantly change between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year marijuana use disorder in Montana was **2.0%** (or **18,000**), similar to both the regional average (**2.3%**) and the national average (**1.6%**).

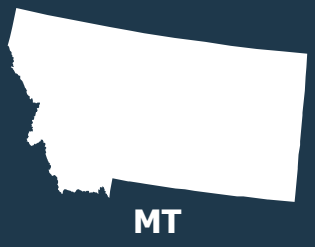


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Substance Use, Misuse, and Use Disorders

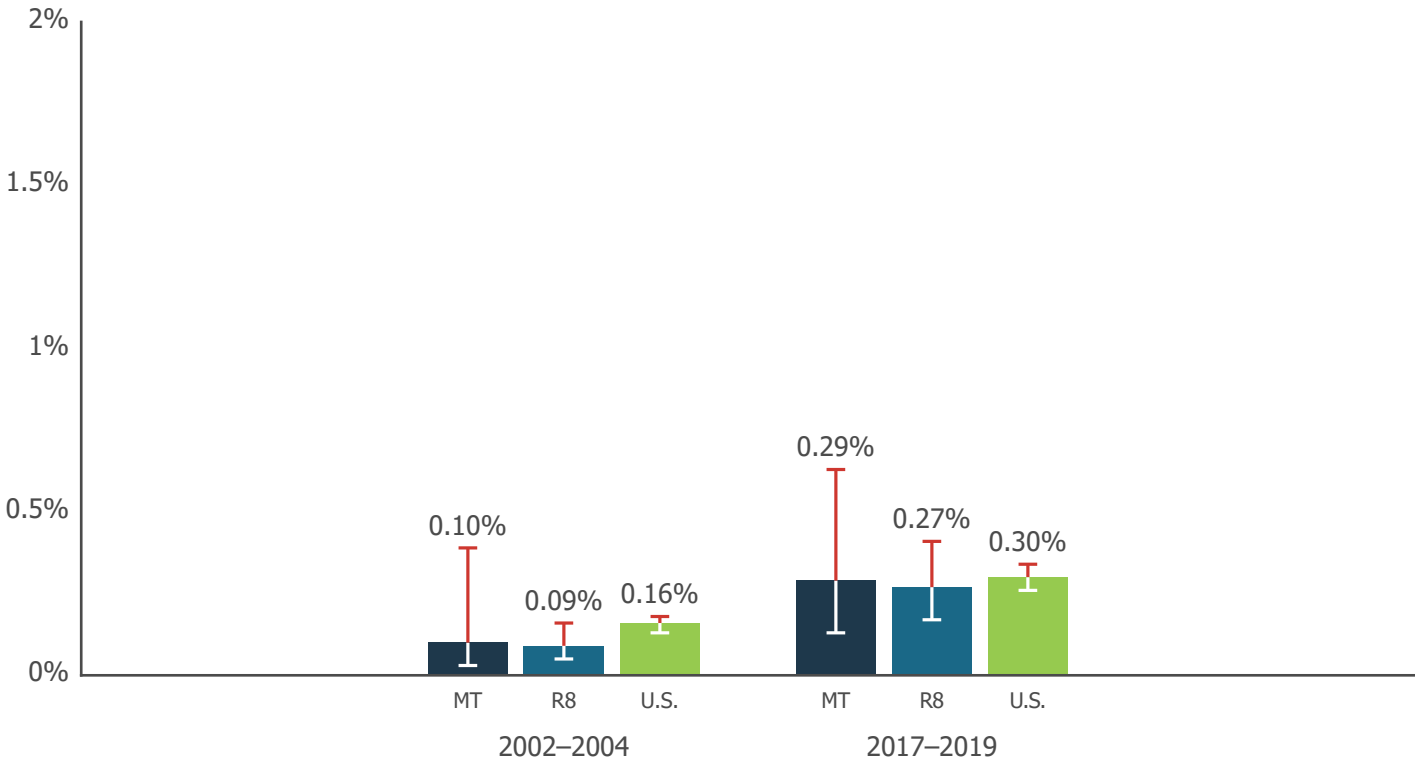
Heroin Use



Changes in Past-Year Heroin Use among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]

Among people aged 12 or older in Montana, the annual average percentage of heroin use in the past year did not significantly change between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year heroin use in Montana was **0.29%** (or **3,000**), similar to both the regional average (**0.27%**) and the national average (**0.30%**).

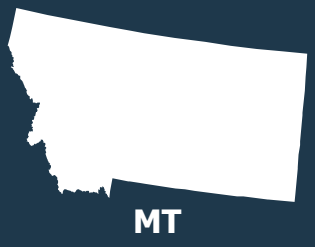


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

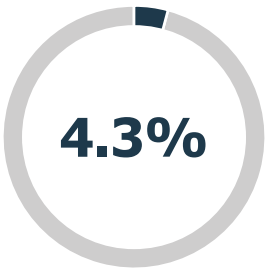
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Substance Use, Misuse, and Use Disorders

Misuse of Prescription Pain Relievers

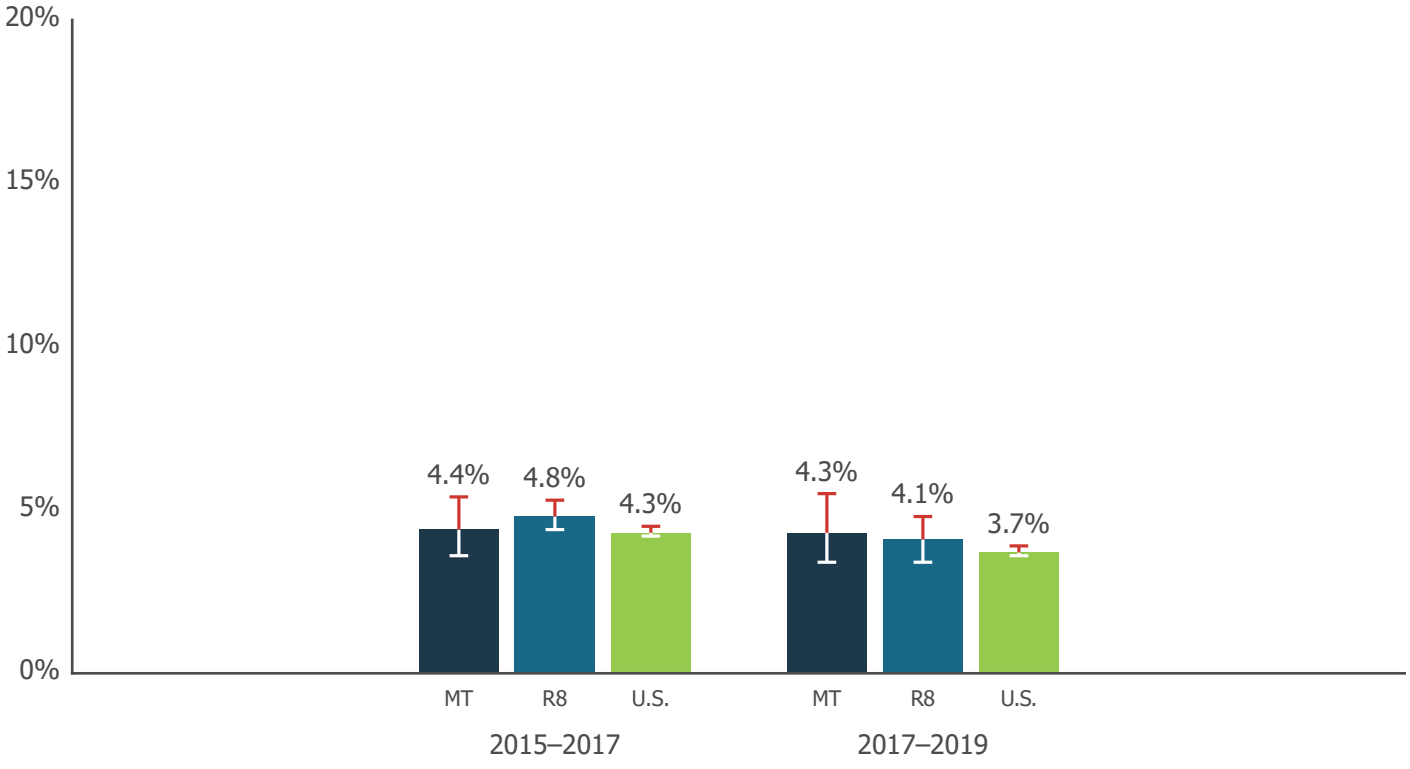


Changes in Past-Year Misuse of Prescription Pain Relievers among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]



Among people aged 12 or older in Montana, the annual average percentage of prescription pain reliever misuse in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year prescription pain reliever misuse in Montana was **4.3%** (or **39,000**), similar to both the regional average (**4.1%**) and the national average (**3.7%**).

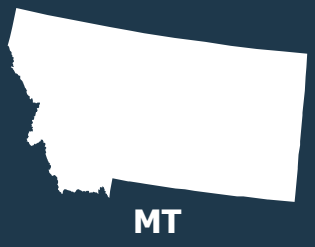


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Substance Use, Misuse, and Use Disorders

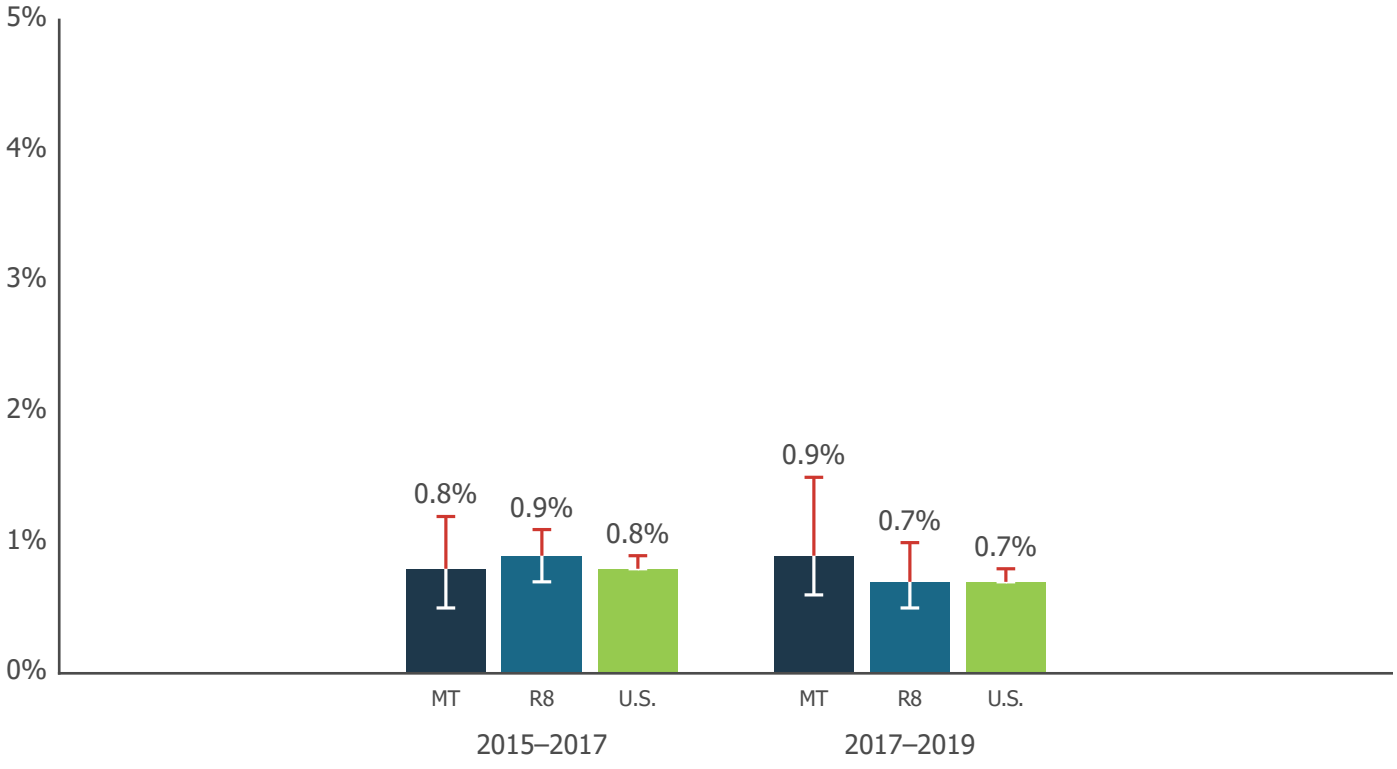
Opioid Use Disorder



Changes in Past-Year Opioid Use Disorder among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]

Among people aged 12 or older in Montana, the annual average percentage of opioid use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year opioid use disorder in Montana was **0.9%** (or **8,000**), similar to both the regional average (**0.7%**) and the national average (**0.7%**).

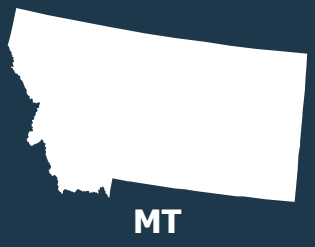


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Substance Use, Misuse, and Use Disorders

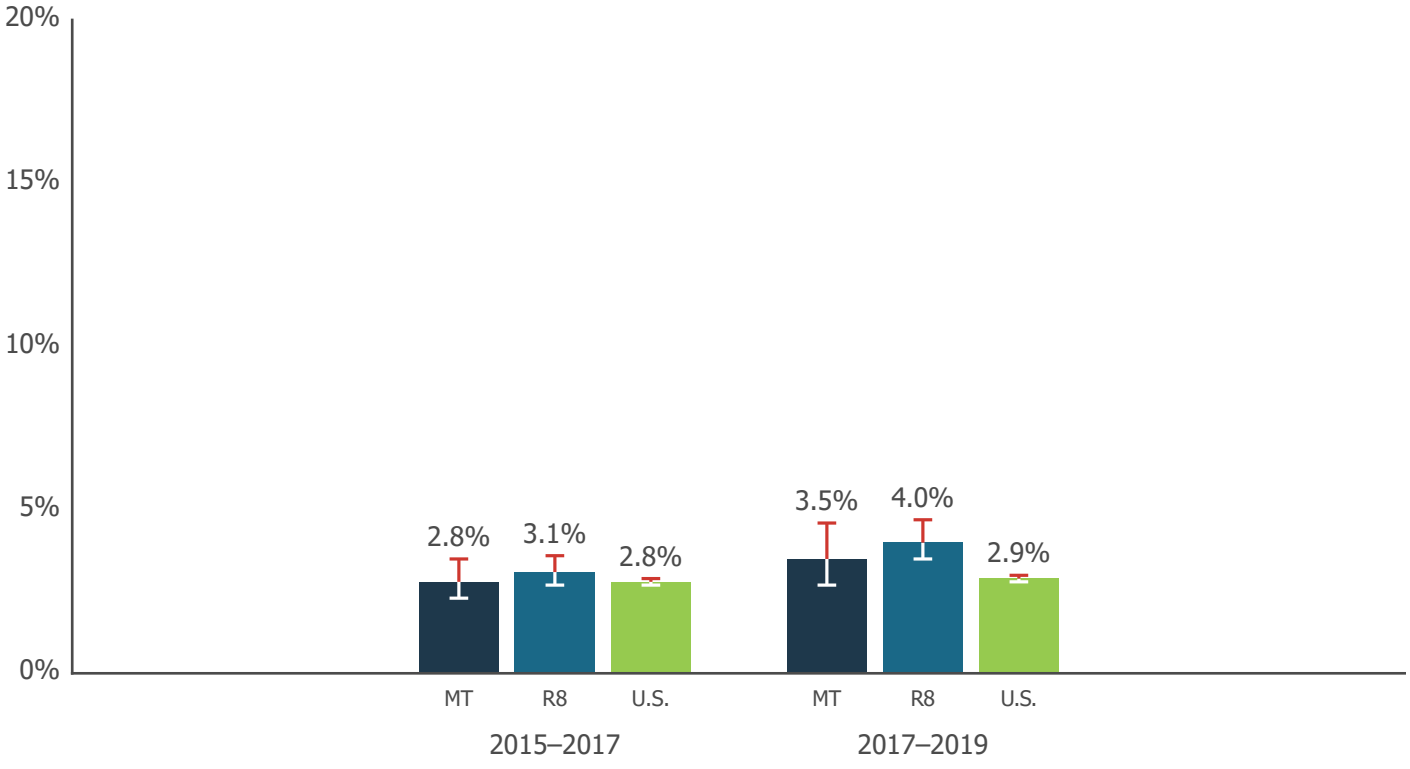
Illicit Drug Use Disorder



Changes in Past-Year Illicit Drug Use Disorder among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]

Among people aged 12 or older in Montana, the annual average percentage of illicit drug use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year illicit drug use disorder in Montana was **3.5%** (or **31,000**), similar to both the regional average (**4.0%**) and the national average (**2.9%**).

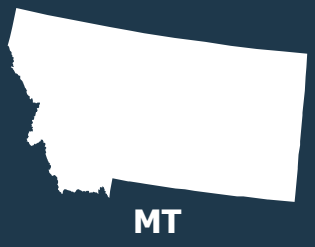


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

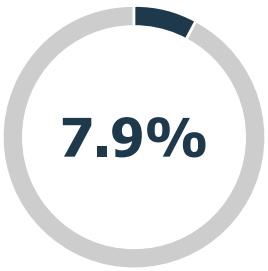
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

Substance Use, Misuse, and Use Disorders

Alcohol Use Disorder

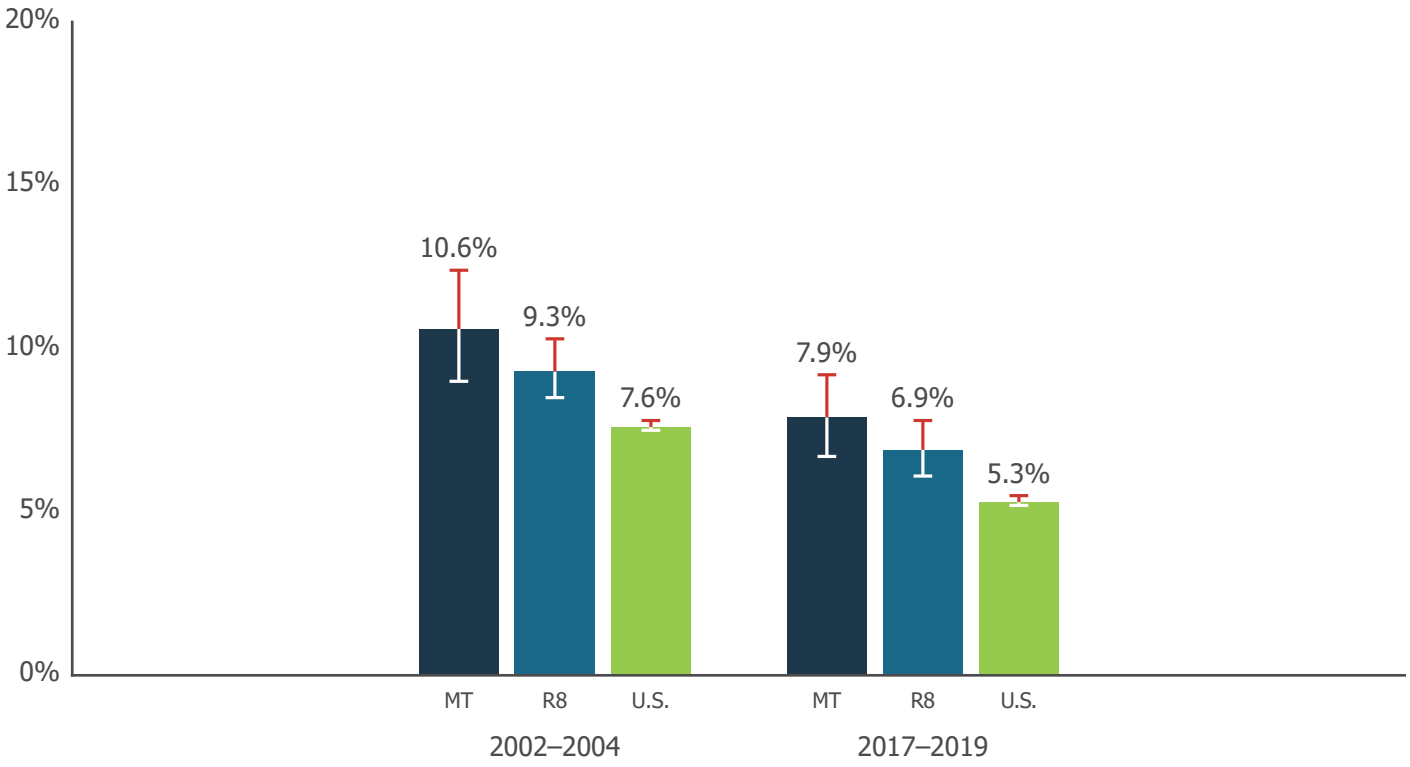


Changes in Past-Year Alcohol Use Disorder among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2002–2004 and 2017–2019)[1]



Among people aged 12 or older in Montana, the annual average percentage of alcohol use disorder in the past year decreased between 2002–2004 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year alcohol use disorder in Montana was **7.9%** (or **70,000**), similar to the regional average (**6.9%**) but higher than the national average (**5.3%**).

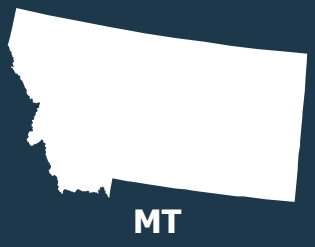


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002–2004 and 2017–2019.

Substance Use, Misuse, and Use Disorders

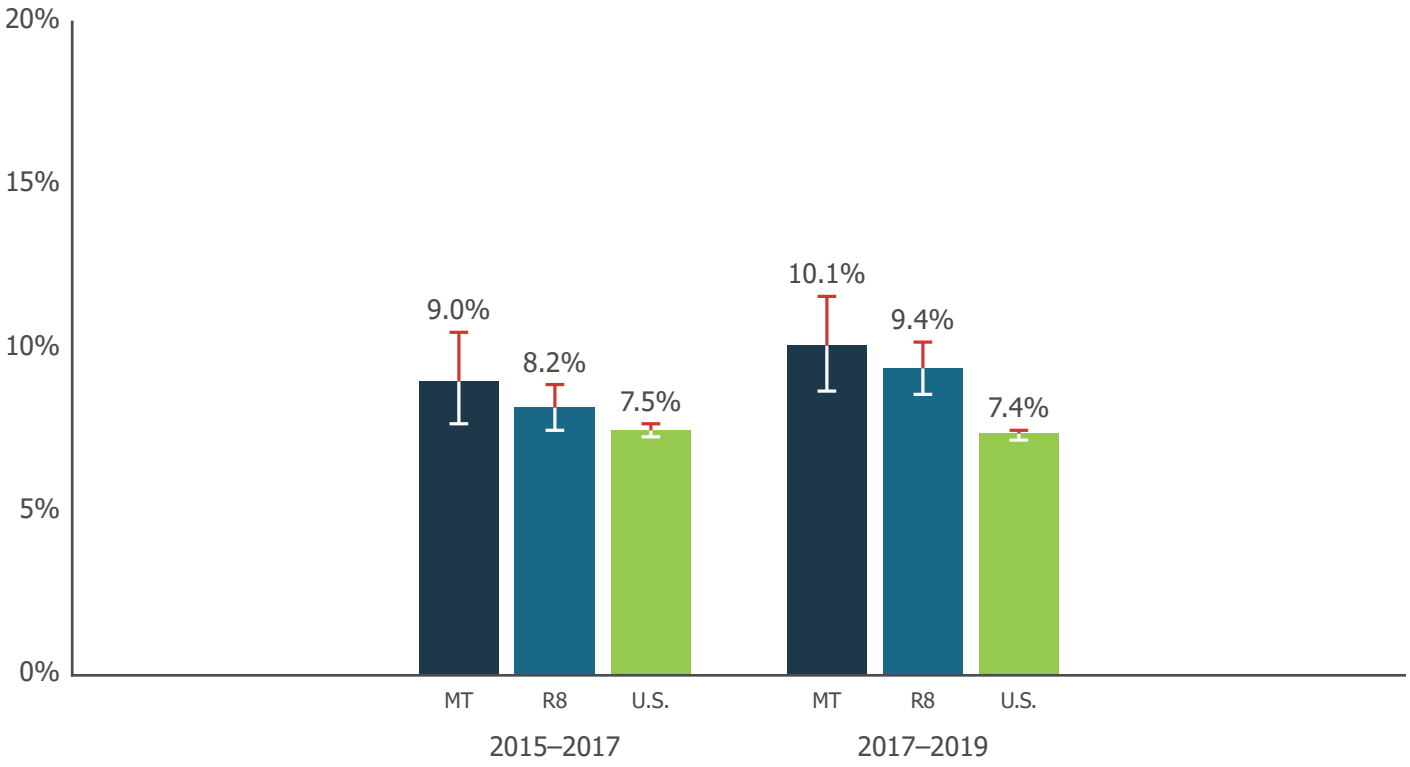
Substance Use Disorder



Changes in Past-Year Substance Use Disorder among People Aged 12 or Older in Montana, Region 8, and the United States (Annual Averages, 2015–2017 and 2017–2019)[1]

Among people aged 12 or older in Montana, the annual average percentage of substance use disorder in the past year did not significantly change between 2015–2017 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year substance use disorder in Montana was **10.1%** (or **90,000**), similar to the regional average (**9.4%**) but higher than the national average (**7.4%**).

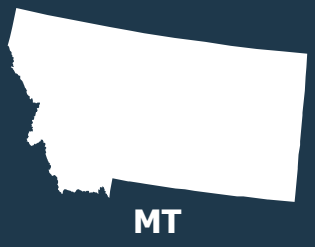


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019.

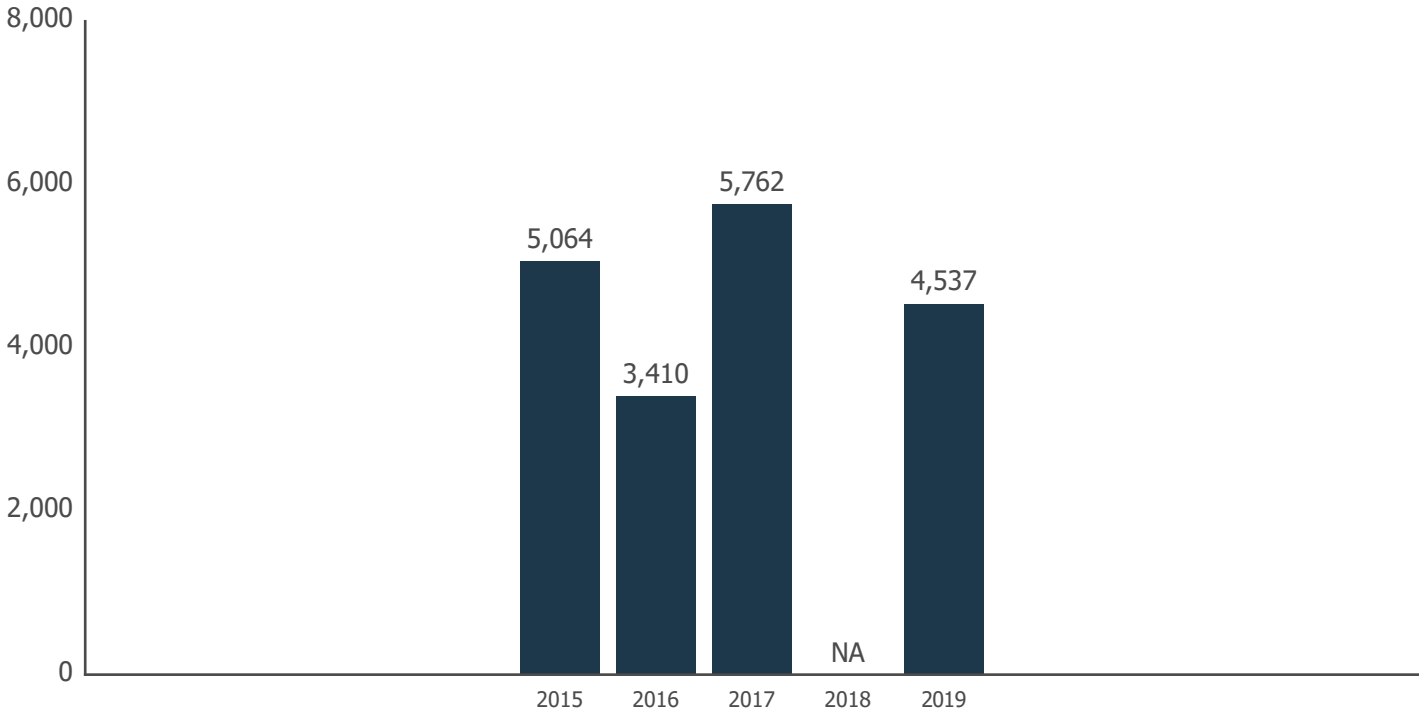
Substance Use Treatment

Enrollment and Treatment Focus



Changes in the Number of People Enrolled in Substance Use Treatment in Montana (Single-Day Counts, 2015–2017 and 2019)[7,8]

In a single-day count in March 2019, **4,537** people in Montana were enrolled in substance use treatment—a decrease from **5,064** people in 2015.

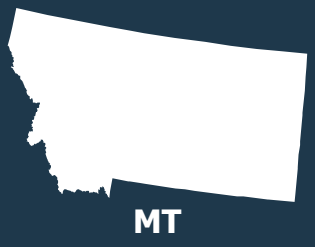


NA = Not Available.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2015–2017 and 2019.

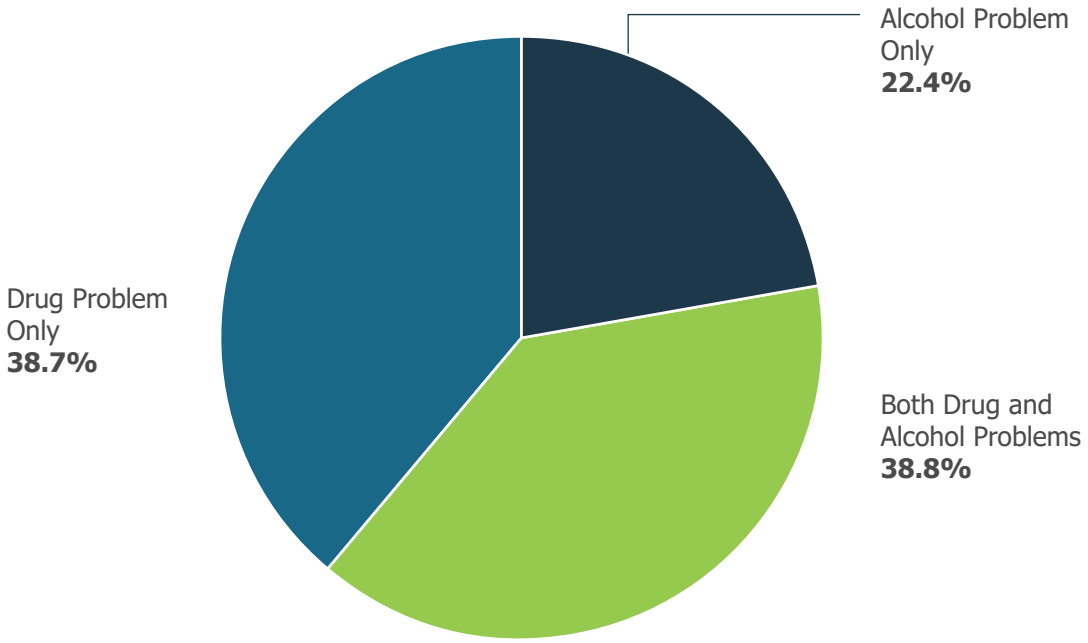
Substance Use Treatment

Enrollment and Treatment Focus



Substance Use Problems among People Enrolled in Substance Use Treatment in Montana (Single-Day Count, 2019)[7,8,9]

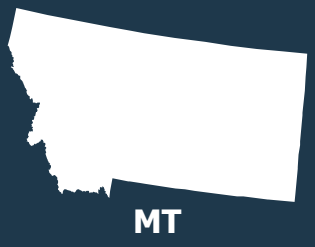
Among people in Montana enrolled in substance use treatment in a single-day count in March 2019, **38.7%** received treatment for a drug problem only, **22.4%** received treatment for an alcohol problem only, and **38.8%** received treatment for both drug and alcohol problems.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2019.

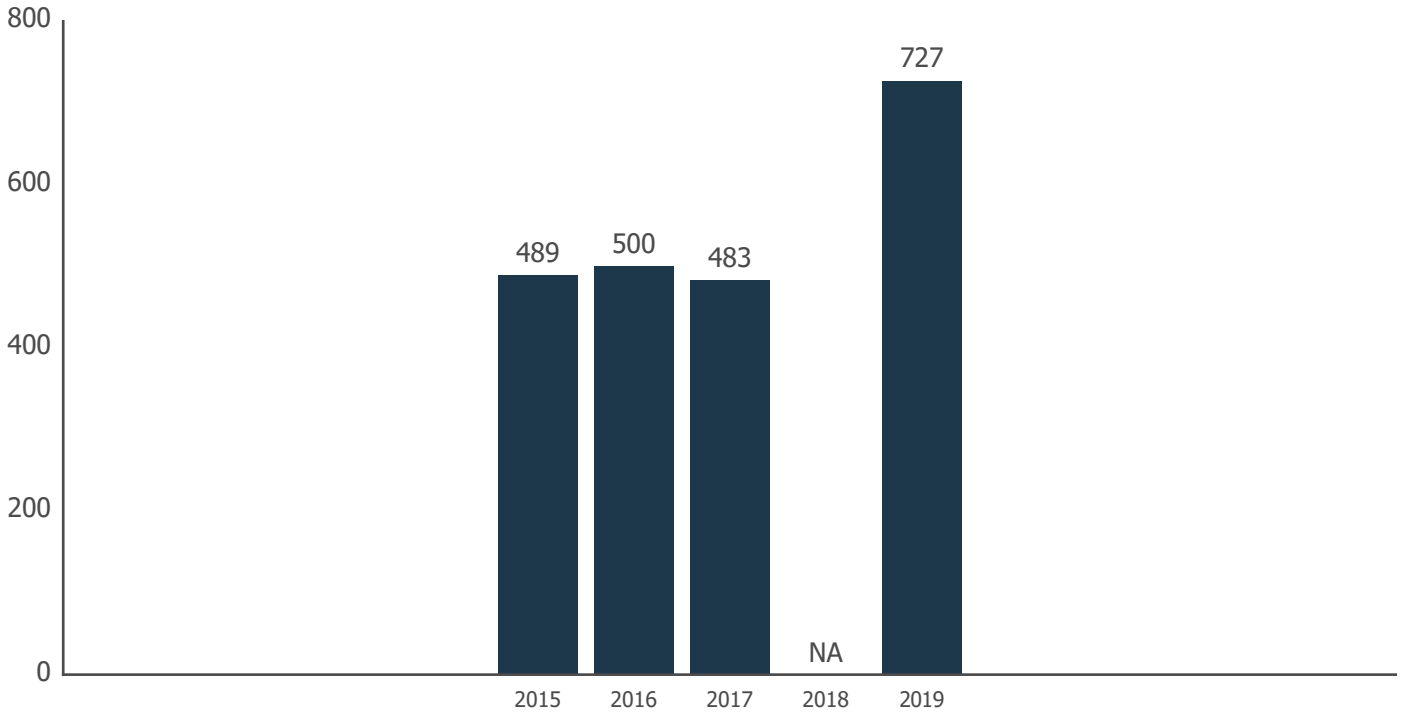
Substance Use Treatment

Opioids (Medication-Assisted Therapy [MAT])



Changes in the Number of People Enrolled in Opioid Treatment Programs in Montana Receiving Methadone (Single-Day Counts, 2015–2017 and 2019)[7,8,10]

In a single-day count in March 2019, **727** people in Montana were receiving methadone in opioid treatment programs as part of their substance use treatment—an increase from **489** people in 2015.

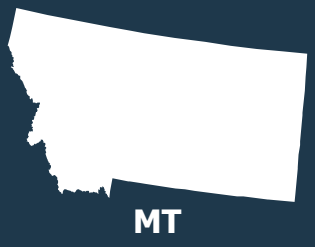


NA = Not Available.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2015–2017 and 2019.

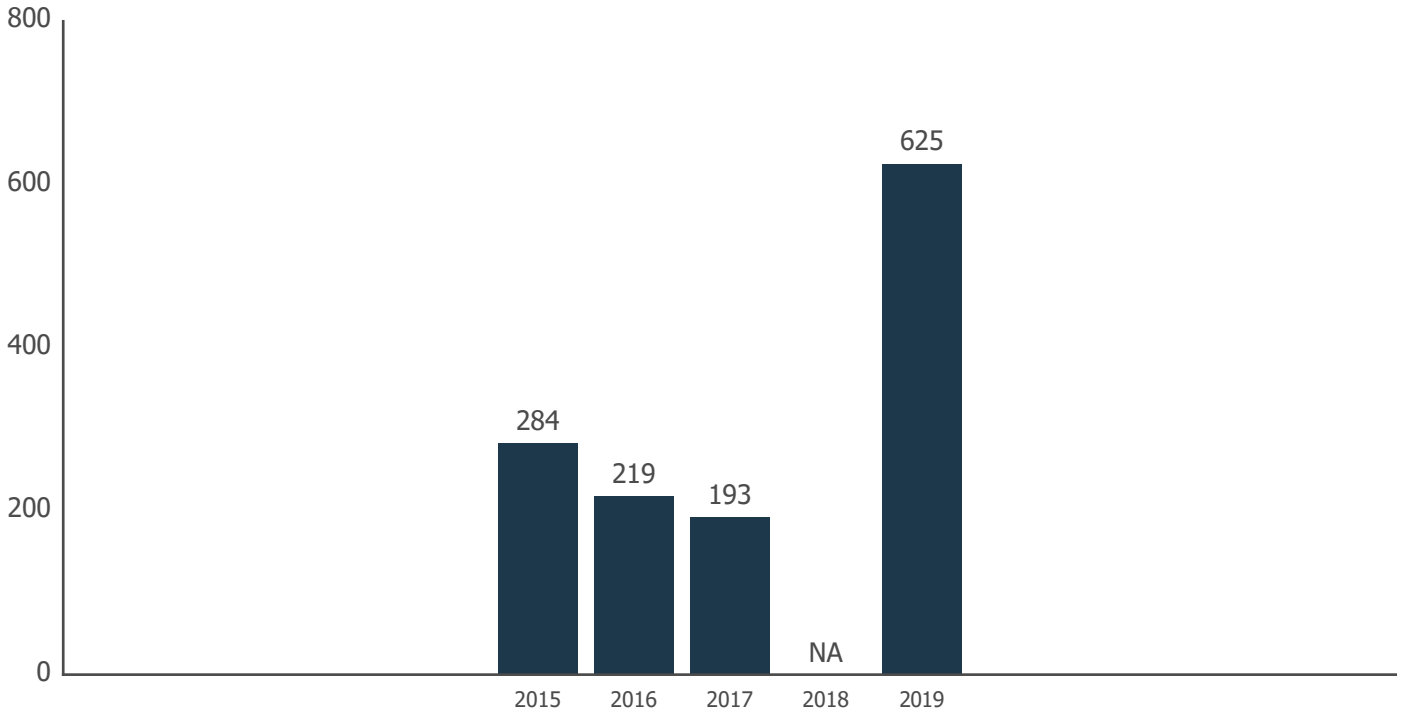
Substance Use Treatment

Opioids (Medication-Assisted Therapy [MAT])



Changes in the Number of People Enrolled in Substance Use Treatment in Montana Receiving Buprenorphine (Single-Day Counts, 2015–2017 and 2019)[7,8,10,11]

In a single-day count in March 2019, **625** people in Montana were receiving buprenorphine as part of their substance use treatment—an increase from **284** people in 2015.

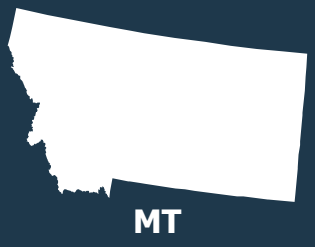


NA = Not Available.

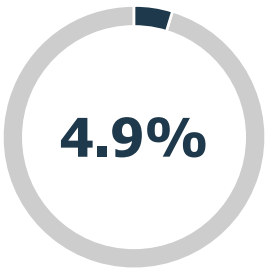
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2015–2017 and 2019.

Adult Mental Health and Service Use

Serious Thoughts of Suicide

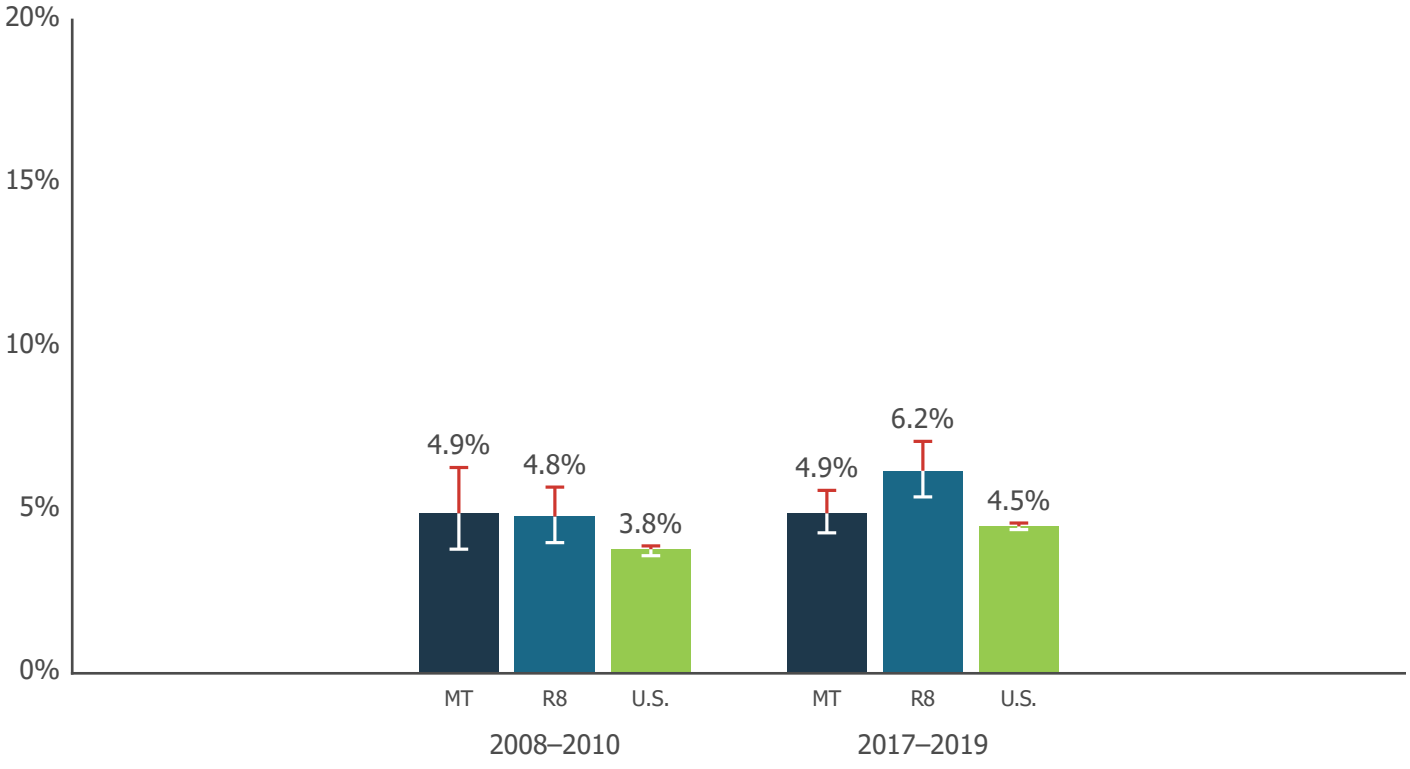


Changes in Past-Year Serious Thoughts of Suicide among Adults Aged 18 or Older in Montana, Region 8, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,5]



Among adults aged 18 or older in Montana, the annual average percentage with serious thoughts of suicide in the past year did not significantly change between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year serious thoughts of suicide in Montana was **4.9%** (or **40,000**), lower than the regional average (**6.2%**) but similar to the national average (**4.5%**).

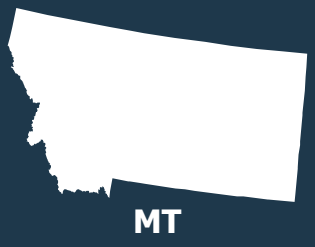


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Adult Mental Health and Service Use

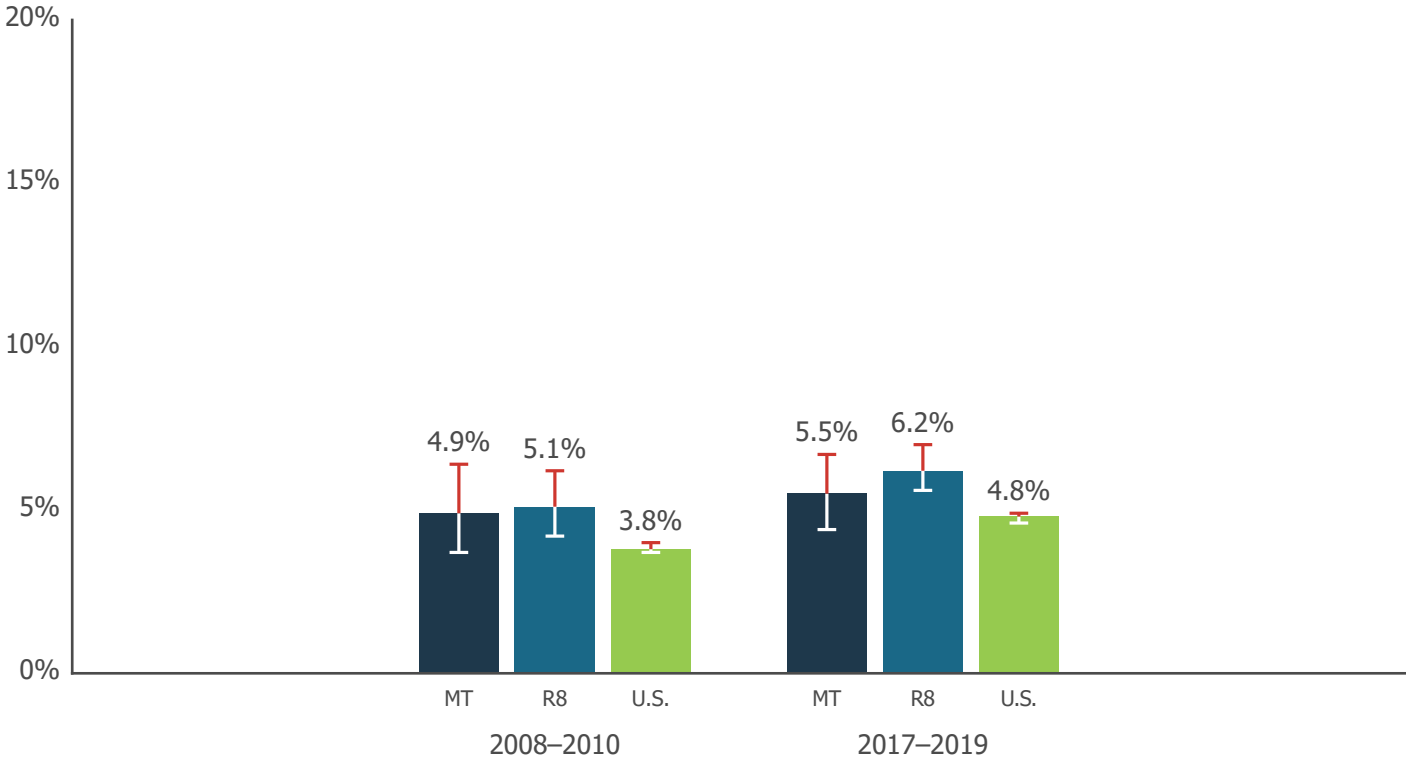
Serious Mental Illness



Changes in Past-Year Serious Mental Illness (SMI) among Adults Aged 18 or Older in Montana, Region 8, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,6]

Among adults aged 18 or older in Montana, the annual average percentage with SMI in the past year did not significantly change between 2008–2010 and 2017–2019.

During 2017–2019, the annual average prevalence of past-year SMI in Montana was **5.5%** (or **45,000**), similar to both the regional average (**6.2%**) and the national average (**4.8%**).

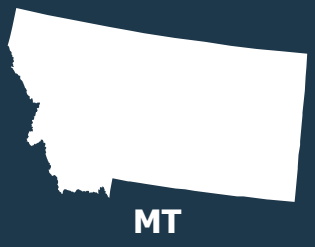


Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

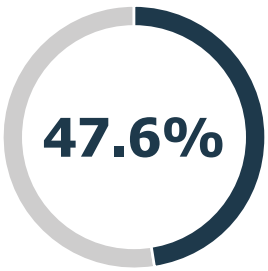
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Adult Mental Health and Service Use

Mental Health Service Use among Adults with Any Mental Illness

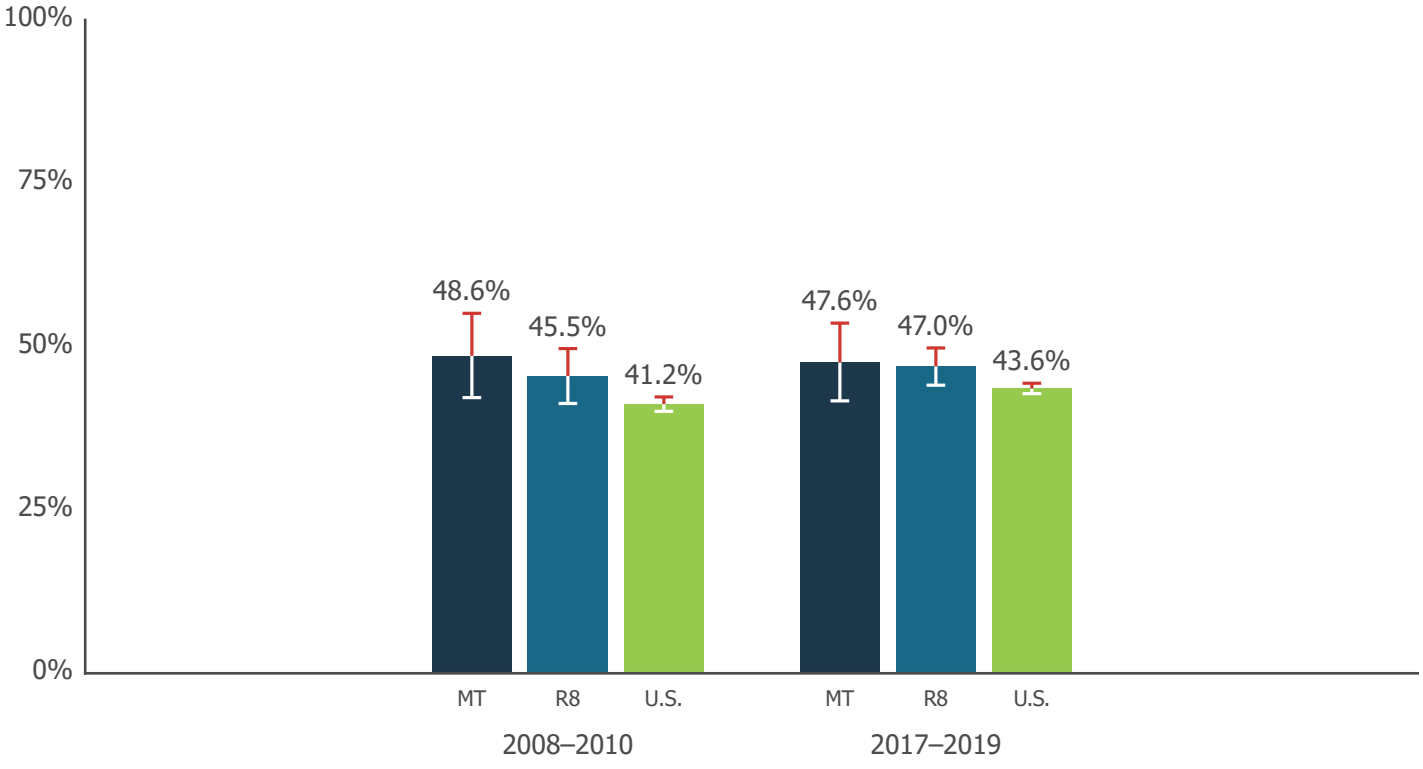


Changes in Past-Year Mental Health Service Use among Adults Aged 18 or Older with Any Mental Illness (AMI) in Montana, Region 8, and the United States (Annual Averages, 2008–2010 and 2017–2019)[1,6,12]



Among adults aged 18 or older in Montana, the annual average percentage with AMI who received mental health services in the past year did not significantly change between 2008–2010 and 2017–2019.

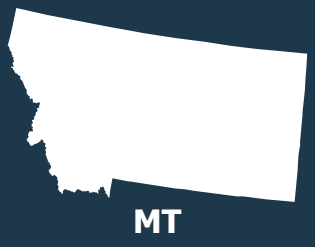
During 2017–2019, the annual average prevalence of past-year mental health service use among those with AMI in Montana was **47.6%** (or **80,000**), similar to both the regional average (**47.0%**) and the national average (**43.6%**).



Error bars indicate 95% confidence interval of the estimate.
MT = Montana; R8 = Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2010 and 2017–2019.

Figure Notes



1 Estimates are annual averages based on combined 2017–2019 NSDUH data or NSDUH data for other combined years as indicated.

2 Respondents with unknown past-year major depressive episode (MDE) data were excluded.

3 Respondents with unknown past-year MDE or unknown treatment data were excluded.

4 Consistent with federal definitions and other federal data collections, the NSDUH definition for binge alcohol use since 2015 differs for males and females. Thus, this indicator is based only on the 2015–2019 NSDUH data. Binge drinking for males is defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days, which is unchanged from the threshold prior to 2015. Since 2015, binge alcohol use for females has been defined as drinking four or more drinks on the same occasion on at least 1 day in the past 30 days.

5 Estimates were based only on responses to suicidality items in the NSDUH Mental Health module. Respondents with unknown suicidality information were excluded.

6 For further information, see *The NSDUH Report: Revised Estimates of Mental Illness from the National Survey on Drug Use and Health*, which is available on the SAMHSA website at https://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.pdf.

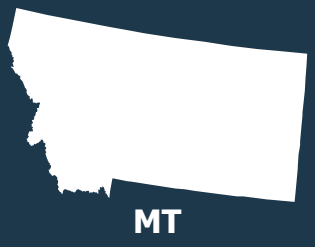
7 Significance testing was not conducted on these data. Conducting statistical significance tests is not necessary because these are counts of people enrolled at all treatment facilities (rather than estimates from a sample of treatment facilities).

8 Single-day counts reflect the number of individuals who were enrolled in substance use treatment on the last business day in March: March 31, 2015; March 31, 2016; March 31, 2017; and March 29, 2019. Single-day counts of the number of individuals enrolled in substance use treatment were not included in the 2018 National Survey of Substance Abuse Treatment Services (N–SSATS).

9 Enrollees whose substances were unknown were excluded.

10 These counts reflect only individuals who were receiving these specific medication-assisted therapies (MATs) as part of their opioid treatment in specialty substance abuse treatment programs; they do not include counts of individuals who were receiving other types of treatment (such as those who received MAT from private physicians) for their opioid addiction on the reference dates.

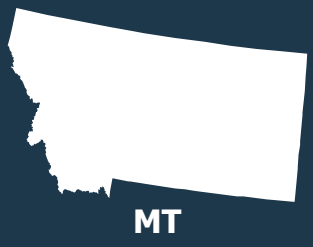
Figure Notes



11 Physicians who obtain specialized training per the Drug Addiction Treatment Act of 2000 (DATA 2000) may prescribe buprenorphine to treat opioid addiction. Some physicians are in private, office-based practices; others are affiliated with substance abuse treatment facilities or programs and may prescribe buprenorphine to clients at those facilities. Additionally, opioid treatment programs (OTPs) may also prescribe and/or dispense buprenorphine. The buprenorphine single-day counts include only those clients who received/were prescribed buprenorphine by physicians affiliated with substance abuse treatment facilities; they do not include clients from private practice physicians.

12 Respondents were not to include treatment for drug or alcohol use. Respondents with unknown service use information were excluded. Estimates were based only on responses to items in the NSDUH Adult Mental Health Service Utilization module.

Definitions



Alcohol use disorder and **illicit drug use disorder** are defined using diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year. For details, see American Psychiatric Association (1994).

Any mental illness (AMI) is defined in NSDUH as adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet DSM-IV criteria. AMI estimates are based on a predictive model applied to NSDUH data and are not direct measures of diagnostic status. Adults estimated as having a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having AMI.

Depression care is defined as seeing or talking to a medical doctor or other professional or using prescription medication for depression in the past year.

Major depressive episode (MDE) is defined as in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), which specifies a period of at least 2 weeks in the past year when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. For details, see American Psychiatric Association (2013).

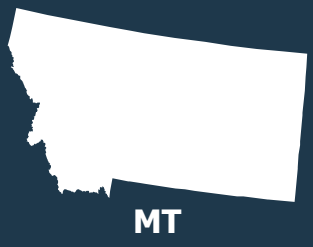
Marijuana use disorder is defined using diagnostic criteria specified within the DSM-IV (APA, 1994), which include such symptoms as tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year.

Mental health service use is defined in the National Survey on Drug Use and Health (NSDUH) for adults aged 18 or older as receiving treatment or counseling for any problem with emotions, nerves, or mental health in the 12 months before the interview in any inpatient or outpatient setting, or the use of prescription medication for treatment of any mental or emotional condition that was not caused by the use of alcohol or drugs.

Number of individuals enrolled in substance use treatment refers to the number of clients in treatment at alcohol and drug abuse facilities (public and private) throughout the 50 states, the District of Columbia, and other U.S. jurisdictions.

Opioid use disorder is defined as heroin use disorder or prescription pain reliever use disorder using diagnostic criteria specified within the DSM-IV (APA, 1994), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year.

Definitions



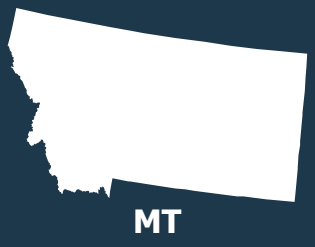
Prescription pain relievers include the following subcategories of pain relievers (examples of specific pain relievers shown in parentheses): *hydrocodone products* (e.g., Vicodin®, Lortab®, Norco®, Zohydro® ER, generic hydrocodone); *oxycodone products* (e.g., OxyContin®, Percocet®, Percodan®, Roxicodone®, generic oxycodone); *tramadol products* (e.g., Ultram®, Ultram® ER, Ultracet®, generic tramadol, generic extended-release tramadol); *codeine products* (e.g., Tylenol® with codeine 3 or 4, generic codeine pills); *morphine products* (e.g., Avinza®, Kadian®, MS Contin®, generic morphine, generic extended-release morphine); *fentanyl products* (e.g., Duragesic®, Fentora®, generic fentanyl); *buprenorphine products* (e.g., Suboxone®, generic buprenorphine, generic buprenorphine plus naloxone); *oxymorphone products* (e.g., Opana®, Opana® ER, generic oxymorphone, generic extended-release oxymorphone); Demerol®; *hydromorphone products* (e.g., Dilaudid® or generic hydromorphone, Exalgo® or generic extended-release hydromorphone); methadone; or any other prescription pain reliever.

Prescription pain reliever misuse is defined as prescription pain reliever use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor.

Serious mental illness (SMI) is defined in NSDUH as adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the DSM-IV and has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. SMI estimates are based on a predictive model applied to NSDUH data and are not direct measures of diagnostic status. The estimation of SMI covers any mental disorders that result in serious impairment in functioning such as major depression and bipolar disorders. However, NSDUH data cannot be used to estimate the prevalence of specific mental disorders in adults. Also, it should be noted that SAMHSA has recently updated the definition of SMI for use in mental health block grants to include mental disorders as specified in the DSM-IV (APA, 1994).

Substance use disorder is defined as dependence on or abuse of alcohol, illicit drugs (e.g., marijuana, cocaine, hallucinogens, heroin, or inhalants), or psychotherapeutics (e.g., prescription pain relievers, sedatives, tranquilizers, or stimulants) in the past 12 months based on assessments of individual diagnostic criteria from the DSM-IV (APA, 1994), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year.

References and Sources



American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (DSM-5) (5th ed.). Arlington, VA: Author.

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the U.S. civilian, noninstitutionalized population aged 12 years or older and includes mental health issues and mental health service utilization for adolescents aged 12–17 and adults aged 18 or older. Conducted by the federal government since 1971, NSDUH collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. The data used in this report are based on information obtained from approximately 67,500 individuals aged 12 years or older per year in the United States. Additional information about NSDUH is available at https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health.

The National Survey of Substance Abuse Treatment Services (N–SSATS) is an annual census designed to collect information from all public and private treatment facilities in the United States that provide substance abuse treatment. The objectives of N–SSATS are to collect multipurpose data that can be used to assist SAMHSA and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, to update SAMHSA's Inventory of Behavioral Health Services, to analyze general treatment services trends, and to generate the Behavioral Health Treatment Services Locator (https://findtreatment.samhsa.gov/). Data presented in this report reflect all publicly available data in N–SSATS reports at the time of the writing of this report and may present data previously unavailable in prior barometer reports. Additional information about N–SSATS is available at https://www.samhsa.gov/data/all-reports.

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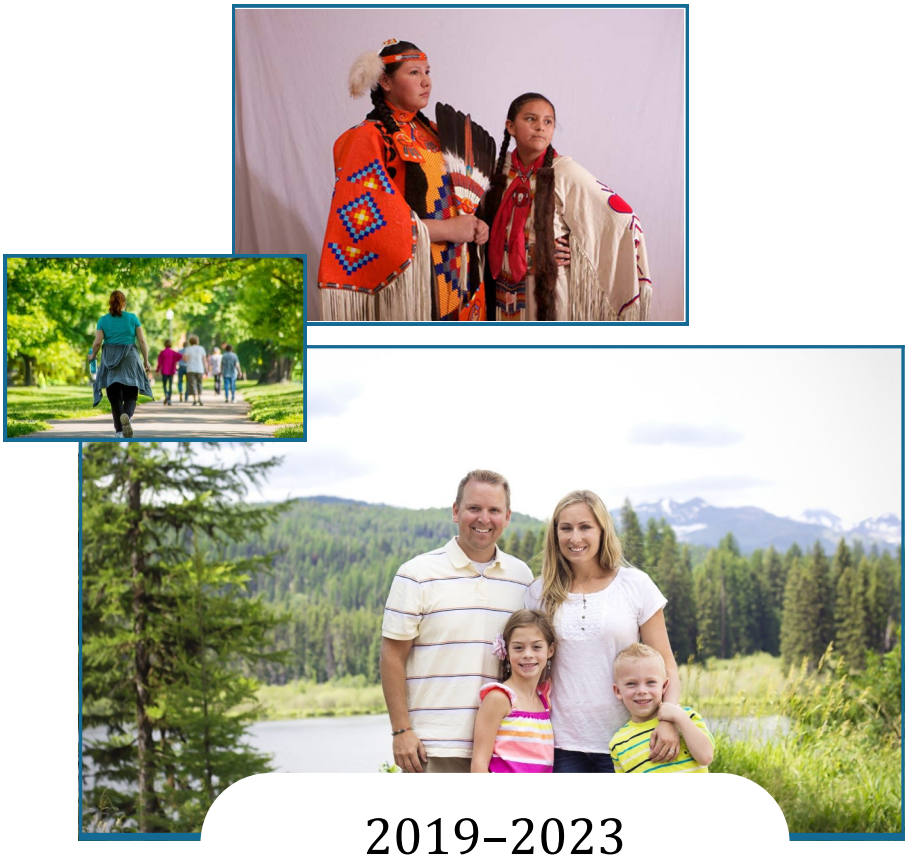
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality

SAMHSA
Substance Abuse and Mental Health Services Administration

Montana State Health Improvement Plan



2019–2023

Healthy Living...Healthy Futures for Montana

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

Updated February 2021

A MESSAGE FROM THE DIRECTOR

Montana is an incredible place to live, work, and raise a family. Healthy people and healthy families are essential for thriving communities and a robust economy.

My vision for Montana, as the Director of the Department of Public Health and Human Services, is "Healthy People, Healthy Communities, Healthy Future." We plan to realize this vision by decreasing health disparities; increasing access to timely, affordable, and effective health services; strengthening prevention efforts to promote health and well-being; and improving the public health system capacity.

Montana has made great strides in promoting health equity and improving population health, but we can always do better to help all Montanans achieve their fullest potential. The 2017 State Health Assessment revealed that Montanans still face challenges, particularly in five priority areas that we have chosen to emphasize in the 2019-2023 State Health Improvement Plan. Those priority areas include:

- Behavioral health;
- Chronic disease prevention and self-management;
- Motor vehicle crashes;
- Healthy mothers, babies, and youth; and
- Adverse Childhood Experiences.

Finally, we know we cannot do this work alone. Over the next five years, we will emphasize creative collaborations with community partners across Montana to achieve the objectives outlined in this State Health Improvement Plan. We also call on the citizens of Montana to take action to maintain and improve their own health and that of their families.

I thank DPHHS staff and partners who worked together to bring you this information.

Working with you for a healthier Montana,

Sheila Hogan

Sheila Hogan, Director
Montana Department of Public Health and Human Services

TABLE OF CONTENTS

INTRODUCTION

Creating and maintaining a healthy Montana is critical to Montana's continued success. Healthy children are better students, healthy adults make a more productive work force, and healthy seniors enjoy more satisfying retirement years. A healthy population is essential to a strong economy, both statewide and in all our communities.

Montana has made progress improving the population's health. We are more physically active and less obese than the U.S. overall. We have made significant reductions in the use of commercial tobacco products among youth. However, many challenges, including substance abuse and mental health issues, still exist.

To ensure the positive health trends are not reversed and to create a healthier Montana, the Public Health and Safety Division (PHSD) of the Montana Department of Public Health and Human Services (DPHHS) initiated a strategic planning process in 2017. Twenty-four members, representing healthcare and public health agencies across the state, served on the steering committee for this process. This steering committee is called the State Health Improvement Coalition and it developed the five-year State Health Improvement Plan (SHIP) contained in this report.

The State Health Improvement Coalition operates under the following mission and guiding principles:

Mission: To protect and improve the health of every Montanan through evidence-based action and community engagement.

Guiding Principles:

- Use evidence-based strategies to address health priorities.
- Use strategies and actions that encourage connections across our communities.
- Promote health equity and value differences in cultures, attitudes, and beliefs.
- Strengthen our public health system to deliver results.

The State Health Improvement Coalition worked together to determine the top health priorities based on available data from the 2017 State Health Assessment, input from stakeholders, and a prioritization matrix.

This document was released for public comment during December 2018 and originally published in February 2019, and re-released in January 2020 to incorporate grammatical edits and refined objectives for improved monitoring and evaluation; several objectives in the version published in February 2019 had yet to have baseline data calculated and targets established, both of which were then included for most objectives. It was updated again in February 2021 with the remaining baselines and targets, as well as objectives that have been added or modified to improve tracking. Details of any updates to the objectives can be found in the most recent Annual Report.

The health priority areas identified to address over the next five years are:

1. Behavioral health, including substance use disorders, mental health, suicide prevention, and opioid misuse;
2. Chronic disease prevention and self-management;
3. Motor Vehicle Crashes (MVCs);
4. Healthy mothers, babies, and youth; and
5. Adverse Childhood Experiences (ACEs).

Each section of the plan describes the health priority, goals, objectives, evidence-based strategies, and key partners. The strategies are categorized in four action areas: prevention and health promotion, clinical/health systems, policy, and health equity.

Supporting Health Equity

The 2017 Montana State Health Assessment (SHA)[1] identified significant health disparities, particularly among American Indian communities. American Indians in Montana have higher mortality rates for many of the leading causes of death, significantly higher premature mortality, and higher prevalence rates for many risk factors and diseases compared to the state overall. Many of Montana's tribes are working on or have completed their Tribal Health Assessments and their Tribal Health Improvement Plans. These plans identify specific health priorities, strategies, and measures that each tribe will be focusing on to improve the health of their communities, many of which are the same as the health priorities outlined in the SHIP. DPHHS is committed to collaborating with the tribes and the Urban Indian Health Centers to address health equity and to improve the health status of American Indian communities. The 2019–2023 SHIP provides a common health agenda and framework for improving the health of all Montanans.

Healthy People 2020

The U.S. Department of Health and Human Services provides science-based, 10-year national objectives for improving the health of all Americans. The current objectives are called *Healthy People 2020*. Healthy People 2020 establishes targets that are measurable, achievable, and applicable at the national, state, and local levels. The 2019–2023 SHIP used Healthy People 2020 targets as benchmarks to establish its objectives. Each objectives section within the SHIP will have a Healthy People 2020 column and the Healthy People 2020 target next to an objective that aligns with a Healthy People (HP) 2020 objective.[2]

Collective Impact

Counties, tribes, and hospitals have identified specific community health priorities and community health improvement plans to address these priorities. It is not expected that counties, tribes, and other partners will focus on each specific priority area and the strategies described in the SHIP. However, through collective action of these organizations in collaboration with their community partners, Montana will make progress to address the health priority areas identified in the SHIP.

Monitoring and Evaluation

The SHIP is designed to be a living document, and will be monitored and updated annually as needed. For more information about SHIP monitoring and evaluation, visit https://dphhs.mt.gov/ahealthiermontana.

Priority Area 1

Behavioral Health

This Priority Area Includes:

- Mental Health
- Substance Use Disorders
- Unintentional Poisonings
- Opioid Misuse
- Suicide Prevention

The Problem:

Poor mental well-being affects thousands of Montanans. One in ten Montana adults (nearly 84,000) report frequent mental distress with 14 or more days of poor mental or emotional health in the past month.[3] Further, 41,000 Montana adults have serious mental illness.[4] Suicide, a mental health crisis, continues to affect every Montana community. Suicide-related deaths in Montana are two times higher than the U.S. An average of 240 suicide deaths occurred each year in Montana from 2011-2015.[5] The suicide rate was significantly higher in rural counties (population less than 10,000) compared to micropolitan (population between 10,000 and 49,999 people) counties.[6] The proportion of American Indian high school students who reported that they had attempted suicide in the past year was nearly two times higher (18%) than youth overall in Montana (10%).[7]

Nearly 64,000 Montana adults struggle with substance use disorder (SUD).[8] Alcohol is the most commonly abused substance in Montana. Use of illicit drugs like marijuana, cocaine, or heroin in Montana follows similar trends as the U.S. Methamphetamines continue to be a major concern in Montana; however, data regarding usage are limited, particularly among Montana's adult population. Among Montana youth, 2.2% of high school students reported having used methamphetamines during their lifetime.[7] Opioids are the leading cause of drug overdose deaths in Montana, accounting for 44% of all drug overdose deaths.

Access to treatment for both SUD and mental health is limited in Montana. Between 2015 and 2016, an estimated 73,500 Montanans aged 12 years and older (8%) needed but did not receive treatment for substance use in the past year.[8] From 2010 to 2014, only 39% of adolescents aged 12 to 17 years with a Major Depressive Episode received treatment within the last year.[9]

It is vital that health care providers are educated on delivery of care from a trauma-informed perspective, particularly in regards to historical trauma within the American Indian communities. The U.S. Administration for Children and Families defines historical trauma as "multigenerational trauma experienced by a specific cultural, racial, or ethnic group."[41] Trauma-informed care emphasizes "understanding, recognizing, and responding to the effects of all types of trauma in order to provide physical, psychological, and emotional safety for both consumers and providers."[42]

Goals:

1. Improve access to timely, affordable, and effective behavioral health services.
2. Prevent and treat depression, anxiety, and other mental health conditions.
3. Decrease the prevalence and adverse consequences of SUD.
4. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.
5. Decrease overdoses and deaths associated with prescription and illicit opiates through coordination of prevention, monitoring, enforcement, treatment, and recovery services.
6. Decrease behavioral health disparities among American Indian communities.
7. Support steps toward the integration of physical and behavioral health care at the community level.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease the proportion of adults who report frequent mental distress (≥14 days in past month with poor mental health status) from 10.4% to 9.9% (Baseline: MT BRFSS, 2016)	
2. Decrease percentage of high school students who report binge drinking in the past month from 17.6% to 16.7% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of high school students who attempted suicide in the past year from 9.5% to 9.0% (Baseline: MT YRBS, 2017)	X
4. Decrease past month alcohol use from 9.9% to 9.4% and illicit drug use from 10.0% to 9.5% among adolescents aged 12 to 17 years (Baseline: MT NSDUH, 2014-2015 and 2013-2014)	X
5. Decrease the proportion of adults who report binge drinking in past 30 days from 19% to 18% (Baseline: MT BRFSS, 2016)	X
6. Decrease opioid overdose death rate from 4.2 per 100,000 people to 3.8 per 100,000 people (Baseline: MT Office of Vital Statistics, 2016)	

Objectives to Improve Health Equity: By 2023

	HP 2020:
1. Decrease proportion of American Indian adults who report frequent mental distress (≥ 14 days in the past month with poor mental health status) from 15.4% to 14.6% (Baseline: MT BRFSS, 2016)	
2. Decrease percentage of American Indian high school students who report binge drinking in the past month from 22% to 21% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of American Indian high school students who attempted suicide in the past year from 18% to 17% (Baseline: MT YRBS, 2017)	X
4. Decrease the proportion of American Indian adults who report binge drinking in past 30 days from 20% to 19% (Baseline: MT BRFSS, 2016)	X

Prevention and Health Promotion Strategies:

- Implement evidence-based strategies in the Montana Suicide Prevention Plan.
- Increase the number of communities implementing the “Communities That Care” model to prevent underage substance use.
- Promote tobacco-free behavioral health programs.
- Implement a statewide public education campaign/media campaign that includes harm reduction, reducing stigma, proper storage and disposal of prescription medications, and awareness of the risks and protective factors to reduce adolescent substance use (such as binge drinking and prescription drug misuse).
- Increase awareness of and support for prescription drop boxes and disposal bags statewide.
- Support local and tribal health departments and non-profit organizations in Montana communities to implement evidence-based Opioid Use Disorder/SUD prevention activities.
- Retain Medicaid expansion.
- Increase access to behavioral health professionals within schools for youth with mental health and substance use needs.

Clinical Strategies:

- Promote routine screening for mental illness, anxiety, depression, SUD, and suicidal ideation in primary care and other medical settings using evidence-based screening tools (i.e. Screening, Brief Intervention, and Refer to Treatment, Alcohol Use Disorders Identification Test, Patient Health Questionnaire, Generalized Anxiety Disorder, and the Columbia Suicide Severity Rating Scale).
- Promote primary care-based interventions and, when appropriate, referrals and engagement in specialty services.
- Increase access to integrated behavioral health services and medical care, including telehealth and increased workforce, particularly in rural and frontier communities.
- Increase and promote use of evidence-based medication-assisted SUD treatment services for SUDs and opioid addiction.
- Increase access to SUD services for pregnant women with SUDs.
- Promote tobacco screening and cessation services and products in behavioral health, primary care, and other health settings.
- Increase training in Adverse Childhood Experiences (ACEs) and trauma-informed care among medical and behavioral health professionals.
- Increase the use of peer recovery supporters as a cost-effective way to improve the timeliness of entry to care and engagement in care throughout the treatment course, and to reduce recidivism after discharge from inpatient or residential treatment and incarceration.
- Train and increase number of Licensed Addiction Counselors and dually-licensed mental health and substance use providers and peer supporters.
- Increase the number of providers who have obtained the required training to prescribe buprenorphine (a DEA x-waiver). Buprenorphine is one of the three FDA-approved medications used to treat opioid addiction as Medication Assisted Treatment (MAT).

Alcohol is the most commonly abused substance in Montana.

Policy Strategies:

- Develop strategies to work across Montana's behavioral health system (mental health and SUD) to align payment reform, address workforce shortages, identify access barriers, ensure rapid and effective crisis response, and provide treatment in the least restrictive environment.
- Increase collaboration and successful "warm handoffs" for individuals admitted to and discharged from state-operated facilities, hospitals, residential behavioral health/psychiatric facilities, and community-based healthcare providers to lower annual readmission rates and to serve individuals in their own communities whenever possible.
- Increase the use of certified behavioral health peer specialists in recovery support to improve timeliness of entry to care and engagement in treatment and to reduce repeat hospitalizations and incarcerations.
- Increase direct collaboration and coordination of services between the SUD and mental health care system and the criminal justice and corrections system.
- Support administrative and legislative policies to increase prescribing according to the Centers for Disease Control and Prevention guidelines.
- Support policies requiring pharmacists to check identification before dispensing narcotics.
- Better utilize the Montana Prescription Drug Monitoring System to prevent over-prescribing of opioids or unintended drug-drug interactions.
- Improve data surveillance of suicide deaths in Montana through participation in the National Violent Death Review System.

Health Equity Strategies:

- Expand culturally relevant behavioral health services for diverse and health disparate populations (American Indian, LGBTQ, veterans, low income, rural, and frontier).
- Increase wraparound support services to individuals receiving or needing behavioral health services (crisis stabilization, care coordination, and recovery support).
- Increase number of integrated behavioral health programs providing SUD services who can access Medicaid reimbursement, including supporting tribally-operated clinics, Urban Indian Health Centers, FQHCs, Rural Health Clinics, and hospitals.
- Foster collaboration, particularly between frontier and rural areas and larger urban centers, to improve continuum of care in communities.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Board of Behavioral Health
- Board of Medical Examiners
- Board of Medicine
- Board of Pharmacies
- Business Leaders
- Community Prevention Partners
- Corrections
- Department of Justice (DOJ)
- DOJ Division of Criminal Investigations
- DPHHS Addictive and Mental Disorders Division
- DPHHS Prevention Resource Center
- DPHHS Public Health and Safety Division
- Department of Revenue
- Department of Transportation
- DUI Task Forces
- Federal Qualified Health Centers
- Hospitals
- Indian Health Service
- Law Enforcement Agencies
- Licensed Mental Health Centers
- Local Advisory Councils
- Local Boards of Health
- Local Health Departments
- Mental Health America
- Montana Association of Counties
- Montana Behavioral Health Association
- Montana Chemical Dependency Center
- Montana Healthcare Foundation
- Montana Hospital Association
- Montana Medicaid
- Montana Medical Association
- Montana Nursing Care Center
- Montana Peer Support Network
- Montana Pharmacy Association
- Montana Primary Care Association
- Montana Public Health Association
- Montana State Hospitals
- Montana State University-Mental Health Research Center
- National Alliance on Mental Illness Montana
- Open Aid Alliance
- Opioid Treatment Programs
- Policy Leaders
- Psychiatric Residential Treatment Facilities
- Public Health Prevention Specialists
- Recovery Support Groups
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Rural Health Clinics
- Schools
- Service Area Authorities
- Tribal Health Departments
- Urban Indian Health Centers
- Veterans Affairs

Priority Area 2

Chronic Disease Prevention and Self-Management

This Priority Area Includes:

- Tobacco Use Prevention and Cessation
- Obesity/Overweight Prevention
- Other Risk Factors for Chronic Disease

The Problem:

Much of the chronic disease burden is attributable to a short list of key risk factors, including tobacco use, obesity, physical inactivity, and poor nutrition. Tobacco use remains the leading cause of preventable death, with 1,600 tobacco-related deaths occurring in Montana each year.[13] Twenty-six percent of Montana adults and 33% of Montana youth currently use some type of tobacco product.[12, 7] This number is even higher for American Indians at 43% for adults and 40% for youth.[12, 7] Obesity results from a combination of poor dietary patterns and physical inactivity. More than one in ten Montana youth (12%) were obese in 2017 and one in four Montana adults (26%) in 2016.[7, 3] Again, this rate is much higher for Montana's American Indian population at 20% for youth and 32% for adults.[7, 3] Seventy-five percent of Montana adults and 72% of Montana youth do not meet the national physical activity recommendations.[7, 14] Montana ranks 46th in the nation for colorectal cancer screening, with only 62% of Montanans up-to-date with screening.[3]

Goals:

1. Prevent commercial tobacco use among youth and adults.
2. Make active living and healthy eating easy, safe, and accessible everywhere Montanans live, work, learn, and play.
3. Increase awareness and decrease prevalence of modifiable risk factors for chronic disease.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease the percentage of Montana adults who currently use tobacco from 26% to 24% (Baseline: MT BRFSS, 2016)	X
2. Decrease the percentage of Montana high school students who currently use tobacco from 33% to 29% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of Montana adults who are currently obese from 26% to 23% (Baseline: MT BRFSS, 2016)	X
4. Decrease the percentage of Montana high school students who are currently obese from 12% to 9% (Baseline: MT YRBS, 2017)	X
5. Increase the percentage of Montana men and women aged 50 to 75 who report being up-to-date with colorectal cancer screening from 62% to 80% (Baseline: MT BRFSS, 2016)	

Tobacco use remains the leading cause of preventable death, with 1,600 tobacco-related deaths occurring in Montana each year.

Objectives to Improve Health Equity: By 2023	HP 2020:
1. Decrease the percent of low-income adults (defined as adults whose household income would qualify for HELP, or salary range less than 138% poverty level) who currently use tobacco from 41% to 39%(Baseline: MT BRFSS, 2018)	X
2. Decrease the percentage of American Indian adults who currently use commercial tobacco from 43% to 39% (Baseline: MT BRFSS, 2016)	X
3. Decrease the percentage of American Indian youth who currently use commercial tobacco from 40% to 36% (Baseline: MT YRBS, 2017)	X
4. Decrease the percent of low-income adults (defined as adults whose household income would qualify for HELP, or salary range less than 138% poverty level) who are currently obese from 31% to 29% (Baseline: MT BRFSS, 2018)	X
5. Decrease the percentage of American Indian adults who are currently obese from 32% to 28% (Baseline: MT BRFSS, 2016)	X
6. Decrease the percent of WIC-enrolled children in Montana (ages 2-4) who are obese from 12% to 10% (Baseline: MT WIC data, 2017)	X
7. Decrease the percentage of American Indian youth who are currently obese from 20% to 15% (Baseline: MT YRBS, 2017)	X
8. Increase the percentage of Medicaid adults aged 50 to 75 who report being up to date with colorectal cancer screening from 9.9% to 10.4% (Baseline: Medicaid data, 2017)	
9. Increase the percentage of American Indian adults aged 50 to 75 who report being up to date with colorectal cancer screening from 46% to 63% (Baseline: MT BRFSS, 2016)	

Prevention and Health Promotion Strategies:

- Implement promising practices and evidence-based programs that facilitate chronic disease prevention and self-management and increase referrals to those programs (e.g. Walk with Ease, Worksite Wellness Programs, Rx Trails, Diabetes Prevention Program [DPP], Diabetes Self-Management Education and Support [DSMES] programs, Baby-Friendly Hospital Initiative, Women, Infants and Children [WIC] Breastfeeding Peer Counselor Program, Montana Tobacco Quit Line, American Indian Commercial Tobacco Quit Line).
- Implement public education campaigns to increase awareness of behaviors that address chronic disease prevention and self-management.
- Increase cancer screening using nationally recognized guidelines for breast, cervical, and colorectal cancers.

Clinical Strategies:

- Advocate for policy and workflow changes within healthcare systems to increase screening, counseling, referrals, and high quality care. Seek out involvement with Urban Indian Health Centers and tribal health departments to participate in such projects.
- Increase referrals to evidence-based chronic disease prevention and self-management programs (e.g. Montana Tobacco Quit Line, American Indian Commercial Tobacco Quit Line, Diabetes Prevention Program [DPP], Diabetes Self-Management Education and Support [DSMES], Walk With Ease, and Chronic Disease Self-Management Programs [CDSMP]).
- Provide ongoing resources and support to birth facilities and staff to become certified by the Baby-Friendly Hospital Initiative.
- Provide ongoing resources and culturally appropriate trainings to support breastfeeding among American Indian populations.
- Refer every WIC participant who is overweight/obese to a registered dietitian for nutrition education.
- Implement evidence-based interventions and supporting strategies to increase breast, cervical, and colorectal cancer screening rates in clinical health system settings.

Policy Strategies:

- Promote improvement and implementation of school wellness policies, including smoke-free and tobacco-free environments in communities and on reservations, access to nutritious food, active transportation, physical education, recreation facilities open to the community, and reduced screen time use.
- Promote and support the implementation of local community active transportation policies.
- Support creation of worksite policies that promote healthy work environments such as increasing opportunities for employees to engage in physical activity and improving access to healthy food.
- Support partners to implement Tobacco 21, include e-cigarettes in local Clean Indoor Air Act protocols, and increase the tobacco tax on all tobacco products.

Health Equity Strategies:

- Develop and disseminate culturally appropriate chronic disease prevention and self-management education materials for target populations.
- Increase access to evidence-based programs for chronic disease prevention and self-management for vulnerable populations (including telehealth to rural and frontier areas, accessibility adaptations for people with disabilities, locations on American Indian reservations, team-based care, training for healthcare professionals, and support for Medicaid members).

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Alliance for Healthy Montana
- American Association of Diabetes Educators
- American Cancer Society
- American Cancer Society Cancer Action Network
- American Diabetes Association
- American Heart Association
- Bike Walk Montana
- Billings Area Indian Health Service
- Comprehensive Primary Care Plus Clinics
- Local Health Departments
- Local Boards of Health
- Million Hearts Workgroup
- Montana Association of Counties
- Montana Diabetes Advisory Coalition
- Montana Diabetes Educators Network
- Montana Medicaid
- Montana Office of Public Instruction
- Montana Primary Care Association
- Mountain-Pacific Quality Health Foundation
- Montana Public Health Association
- Montana State University Office of Rural Health
- Montana Tobacco Prevention Specialists
- NASPA (Student Affairs Administrators in Higher Education)
- Patient-Centered Medical Homes Clinics
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- State of Montana Health Care & Benefits Division
- The Sonoran Institute
- Stroke Workgroup
- Tribal Health Departments
- University of Montana Rural Institute Disability & Health Program
- Western Transportation Institute

Priority Area 3

Motor Vehicle Crashes

This Priority Area Includes:

- Motor Vehicle Crash-Related Injury and Mortality
- High-Risk Driving Behaviors

The Problem:

Motor vehicle crashes (MVCs) are one of the most common causes of both fatal and non-fatal injuries in Montana. MVCs result in huge medical and productivity loss, especially since younger people are disproportionately affected.[15] High-risk driving behaviors, such as not wearing a seatbelt consistently, speeding, impaired driving, and distracted driving, are prevalent in Montana.[16]

From 2011–2016, 60% of all MVC related fatalities involved a driver impaired by alcohol or drugs, and among fatalities to occupants of vehicles with seatbelts available, nearly 67% were unrestrained.[17] Distracted driving is also common; 54% of high school students reported texting or emailing while driving in 2017.[7]

From 2011–2016, Montana had an unintentional motor vehicle fatality rate of 19 per 100,000 people compared to the national rate of 11 per 100,000. During this time period, the MVC mortality rate was more than three times higher among American Indians than whites.[18] Furthermore, from 2011-2015, Montana residents of rural counties (populations of less than 10,000 people) had more than double the MVC mortality rate than residents of micropolitan or small metro counties.[5]

Goal:

1. Prevent deaths and traumatic injuries due to motor vehicle crashes by mitigating the pre-crash, during crash, and post-crash factors among Montanans overall and among American Indians.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease age-adjusted mortality rate due to MVCs from 19 deaths per 100,000 people to 12 deaths per 100,000 (Baseline: MT Office of Vital Statistics, 2012-2016)	X
2. Increase the proportion of adult motor vehicle occupants that report always wearing seatbelts from 75% to 79% (Baseline: MT BRFSS, 2016)	X
3. Increase the proportion of high school students that report always wearing seatbelts while riding in a car driven by someone else from 52% to 55% (Baseline: MT YRBS, 2017)	X
4. Decrease the proportion of MVC fatalities that involve alcohol-impaired drivers from 40% to 38% (Baseline: FARS, 2012-2016)	
5. Decrease proportion of high school students who report texting or emailing while driving from 54% to 51% (Baseline: MT YRBS, 2017)	
6. Decrease age-adjusted rate of non-fatal ED visits related to MVCs from 409 per 100,000 people to 388 per 100,000 (Baseline: MHDDS, 2016)	
7. Decrease age-adjusted rate of non-fatal hospitalizations related to MVCs from 38 per 100,000 people to 36 per 100,000 (Baseline: MHDDS, 2016)	

Objectives to Improve Health Equity: By 2023	HP 2020:
1. Decrease age-adjusted mortality rate due to MVCs among American Indians from 55 per 100,000 people to 52 per 100,000 people (Baseline: MT Office of Vital Statistics, 2012-2016)	X
2. Increase the proportion of adult American Indian motor vehicle occupants that report always wearing seatbelts from 69% to 72% (Baseline: MT BRFSS, 2016)	X
3. Increase the proportion of American Indian youth less than 18 years of age that report always wearing seatbelts while riding in a car driven by someone else from 32% to 34% (Baseline: MT YRBS, 2017)	X
4. Decrease age-adjusted rate of non-fatal healthcare visits due to MVCs among American Indians from 660 per 100,000 people to 627 per 100,000 (Baseline: IHS NDW, 2017)	
5. Increase the average seatbelt use rate for vehicle occupants in the Billings Area IHS observational seat belt survey (Montana service units) from 27% to 29% (Baseline: Billings Area IHS, 2018)	

Prevention and Health Promotion Strategies:

- Promote Montana Department of Transportation's (MDT) Comprehensive Highway Safety Plan's Vision Zero: zero deaths and zero serious injuries on Montana roadways.
- Support efforts of MDT SOAR project (Safe On All Roads), which focuses on reducing American Indian traffic fatalities and serious injuries.
- Increase awareness of high-risk driving behaviors.
- Support improved surveillance of MVCs through data linkages.
- Support efforts of the MDT teen peer-to-peer traffic safety program and campaigns.

Clinical Strategies:

- Support further development of the trauma system (both EMS and trauma facilities) to reduce severity of injury outcomes.

Policy Strategies:

- Support primary seatbelt law.
- Support policies to reduce distracted driving.
- Support increasing age requirements on child passenger restraints from aged 5 years to 8 years.
- Support increasing age requirements for graduated licensing learners permits from aged 14 years to 16 years.
- Support increasing age requirements for graduated licensing unrestricted license from aged 16 years and 6 months to 18 years old.
- Encourage the use of alcohol/drug monitoring, such as the 24/7 program (which includes ignition interlocks), for DUI offenders.
- Encourage community design policies that keep all road users safe.
- Engage with tribal governments to implement proven policy interventions in their jurisdictions.

Health Equity Strategies:

- Utilize data on age groups, geographic regions, and gender to identify high-risk groups.
- Develop and implement culturally competent materials and programs to address disparities in MVC fatalities and high-risk driving behaviors.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Billings Area Indian Health Service
- City Planners
- Montana's Comprehensive Highway Safety Plan Partners
- Department of Corrections
- Department of Justice
- Department of Revenue
- Highway Patrol
- Local Health Departments
- Local Boards of Health
- Montana Association of Counties
- Montana Department of Transportation
- Montana Judicial Branch
- Montana Public Health Association
- Office of Public Instruction
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Schools
- Sheriffs
- Tribal Governments
- Tribal Health Departments

High-risk driving behaviors, such as not using a seatbelt consistently, speeding, impaired driving, and distracted driving are highly prevalent in Montana.

Priority Area 4

Healthy Mothers, Babies, and Youth

This Priority Area Includes:

- Unintended Pregnancy
- Breastfeeding
- Low Birth Weight
- Pre-Term Births

The Problem:

The well-being of mothers, infants, and children influences the health of the next generation and forecasts the future health challenges of Montana families, communities, and the health care system. Unintended pregnancy can result in adverse maternal and child health outcomes. In 2015, 32% of Montana births were unintended and of these, 7% were the result of an unwanted pregnancy.[19] Among American Indian women and young adult women (aged 18 to 24 years), one in three pregnancies are reported as intended.[19] Women with unintended pregnancies are more likely to engage in risky behaviors during pregnancy, such as smoking and drinking. Drinking alcohol while pregnant can cause Fetal Alcohol Spectrum Disorders (FASD), which can lead to intellectual and developmental disabilities for the growing child.[40]

Approximately 12,000 live births occur each year in Montana, and while the infant mortality rate remains lower than the national rate (5.7 and 6.2 deaths per 1,000 births, respectively), American Indians are disproportionately affected with a rate of 10 per 1,000 births.[20] The majority of infant deaths in Montana are sleep-related incidents.[21]

In 2015, the American Academy of Pediatrics reported the national breastfeeding initiation rate was 65% while the rates among WIC participants was 70%. Montana's WIC breastfeeding rate at 78% is higher than the national WIC rate, but lower than the Healthy People 2020 target rate of 82%.[22, 23] However, the American Indian women participating in Montana's WIC program had a much lower rate of breastfeeding initiation (63%) than white women in the same program.[22]

Each year in the United States, approximately 8% low birth weight (LBW) births (less than 2,500 grams) and 10% preterm births (PTB) (less than 37 weeks gestation) occur. LBW and PTB are associated with numerous poor birth outcomes including respiratory distress syndrome, retinopathy, jaundice, infections, and other serious conditions. LBW and PTB are associated with diabetes, heart disease, high blood pressure, developmental disabilities, and obesity later in life.[24] Montana's American Indian populations have disproportionately higher rates of PTB at 13% compared to 9% for all Montana births.[25]

Goals:

1. Decrease unintended pregnancies by increasing the use of effective contraception methods.
2. Increase home visiting services for all Montana families.
3. Increase education and awareness of the importance of prenatal care, birth outcomes, postpartum care, and childhood health.
4. Increase childhood and adolescent immunizations.
5. Decrease maternal and child health disparities among American Indian populations.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease the infant mortality rate for all Montanans from 6 per 1,000 live births to 5 per 1,000 live births (Baseline: MT Office of Vital Statistics, 2016)	X
2. Decrease the number of sleep-related infant deaths from 1.4 per 1,000 to .84 per 1,000 (Baseline: MT DPHHS FICMR Data System, 2016)	
3. Decrease the percentage of births resulting from unintended pregnancy from 23% to 22% (Baseline: PRAMS, 2017)	X
4. Decrease the percent of live births that were low birth weight (less than 2,500 grams) for all Montanans from 7.9% to 5.9% (Baseline: MT Office of Vital Statistics, 2016)	X
5. Decrease the prevalence of premature births (less than 37 weeks gestation) for all Montanans from 9% to 7% (Baseline: MT Office of Vital Statistics, 2016)	X
6. Increase the percentage of pregnant women who receive early and adequate prenatal care from 86% to 91% (Baseline: MT Office of Vital Statistics, 2016)	X
7. Increase breastfeeding initiation rates of WIC-participating infants from 78% to 82% (Baseline: MT DPHHS WIC Data System, 2017)	X
8. Increase the percentage of children aged 24–35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine from 62% to 70% (Baseline: National Immunization Survey, 2018)	X
9. Increase the percentage of adolescents aged 13–17 years who have at least one dose each of Tetanus, Diphtheria and Pertussis (Tdap), Meningococcal (MCV4), and Human Papillomavirus (HPV) from 90% (Tdap), 71% (MCV4), and 49% (HPV) to 93%, 80%, and 70% respectively (Baseline: National Immunization Survey, 2017)	
10. Increase the percentage of people immunized against influenza in all children aged 6 months to 17 years from 49% to 60%, adults aged 19 to 64 years from 34% to 60%, and adults aged 65 and older from 65% to 70% (Baseline: National Immunization Survey, BRFSS, 2017-2018)	X
11. Increase the percentage of women who are screened for postpartum depression after delivery from 91% to 96% (Baseline: PRAMS, 2017)	
12. Increase the percentage of babies in safe sleep environments from 80% to 84% (Baseline: PRAMS, 2017)	

Objectives to Improve Health Equity: By 2023	HP 2020:
1. Decrease the infant mortality rate for American Indians from 13 per 1,000 live births to 11 per 1,000 live births (Baseline: MT Office of Vital Statistics, 2016)	X
2. Decrease the percent of live births that were preterm births (less than 37 weeks gestation) for American Indians from 13% to 11% (Baseline: MT Office of Vital Statistics, 2016)	X
3. Increase the percent of pregnant women who receive early and adequate prenatal care for American Indians from 41% to 43% (Baseline: MT Office of Vital Statistics, 2016)	X
4. Increase breastfeeding initiation rates of American Indian infants from 80% to 84% (Baseline: PRAMS, 2017)	X
5. Establish a baseline measure for children aged 19–35 months enrolled in Medicaid who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine	X

Breastfeeding has numerous health benefits for both mother and infant. Montana's WIC breastfeeding rate at 78% is higher than the national WIC rate.

Prevention and Health Promotion Strategies:

- Promote the use of effective birth control methods for women not desiring pregnancy, especially for youth, low-income women, and American Indian women.
- Promote home visiting services through outreach to health clinics, local and tribal health departments, WIC, birthing hospitals, and local Child Protective Service (CPS).
- Provide Breastfeeding Peer Counseling services at local agencies and Breastfeeding Learning Collaborative training at Baby-Friendly Hospitals.
- Promote and increase the number of local and tribal health departments that provide access to public health services and education, child immunizations, and postpartum care.
- Promote and increase the number of local and tribal health departments providing education and support of safe-sleep environments.
- Increase awareness about adult vaccines, including influenza.
- Participate in HPV/Adolescent Working Group activities, including MT TeenVax.

Clinical Strategies:

- Increase the percentage of Title X Family Planning clients and Medicaid members using effective birth control methods.
- Increase the number of health systems implementing pregnancy support interventions, such as the Medicaid Promising Pregnancy Care program.
- Build new functionality into imMTrax, the state immunization registry, so clinics can review coverage levels in real time.
- Provide monthly missing immunization reports to participating providers.
- Pilot stand-alone clinic assessment (AFIX) visits for select providers.
- Health systems adopt integrated, team-based behavioral health services to screen for and treat perinatal SUD and mental illness during prenatal care.

Policy Strategies:

- Implement evidence-based teen pregnancy prevention programming in Montana public schools.
- Support integration and collaboration between Maternal and Child Health population-based programs with other DPHHS programs that support this group (e.g., asthma home visiting, tobacco cessation, chronic disease self-management, and communicable diseases prevention and treatment for Sexually Transmitted Infections, immunizations, and HIV/AIDS).
- Annually examine existing requirements for licensed childcare facilities and update as necessary to align, as feasible, with the Advisory Committee on Immunization Practices.

Health Equity Strategies:

- Develop culturally competent materials for American Indian communities.
- Promote the use of social media to reach youth populations.
- Secure funding for public health programs that serve low-income populations.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Best Beginnings
- Healthy Mothers, Healthy Babies
- Indian Health Service
- Local Health Departments
- Local Boards of Health
- Montana Association of Counties
- Montana Health Care Foundation
- Montana Medicaid
- Montana Medical Association
- Montana Office of Public Instruction
- Montana Office of Vital Statistics
- Montana Personal Responsibility and Education Program
- Montana Primary Care Association
- Montana Public Health Association
- Montana Title X Family Planning Program
- Mountain-Pacific Quality Health Foundation
- National Campaign to Prevent Teen and Unintended Pregnancy
- Office of Population Affairs
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Service Area Authorities
- Tribal Health Departments
- Urban Indian Health Centers

Priority Area 5

Adverse Childhood Experiences (ACEs)

A Cross-Cutting Issue

The Problem:

Adverse Childhood Experiences (ACEs) are traumatic events and include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, substance misuse within the household, household mental illness, parental separation or divorce, and having an incarcerated household member. The harmful effects of ACEs on health status throughout the lifespan have been well documented.[35]

Studies have shown an association between ACEs and chronic disease, behavioral health issues, and initiation of risky health behaviors. Studies have also documented a dose-response relationship between ACEs and adverse health and behavioral health outcomes, meaning that persons with more ACEs (a higher ACE score) are more likely to have more adverse health outcomes.[30]

A recent systematic review and meta-analysis of the published literature on ACEs indicated that persons with four or more ACEs were at increased risk for all negative health outcomes examined in the study. The strongest associations were found with problematic drug use, interpersonal and self-directed violence, sexual risk taking, poor mental health, and problematic alcohol use, followed by moderate associations with smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, and respiratory disease. While considered weak or modest, associations were nonetheless documented with physical inactivity, overweight or obesity, and diabetes.[31]

Since multiple ACEs can be considered a major risk factor for many health conditions, a public health approach to ACEs and childhood trauma is warranted. While clinical treatment of psychological trauma is well-established, population-based strategies for prevention are still emerging.[33]

Recognizing ACEs/trauma-informed strategies need to be applied across the health priorities addressed in this plan, the SHIP Coalition determined this special section of the plan should describe key cross-cutting strategies. Every effort should be made to support populations that are potentially disproportionately affected by this issue. In 2011, 60% of Montana adults reported having one or more ACEs. A higher percent of American Indian than white non-Hispanic adults reported experiencing four or more ACEs, as did adults who had not completed high school compared to those who had more education, adults with lower annual incomes compared to those with higher incomes, and adults with disabilities compared to those without disabilities.[32]

ACEs Strategies:

- Implement community-based strategies recommended by the Centers for Disease Control and Prevention to prevent ACEs and trauma and increase resiliency, including: providing quality and affordable child care and education early in life; strengthening economic supports for families; changing social norms to support parents and positive parenting; enhancing parenting skills to promote positive child development; and intervening to lessen harms and prevent future risk to children.[38]
- Integrate knowledge about the wide-spread effects of ACEs and trauma into policies, procedures, practices, and environments of health, human service, education, and other organizations serving children, with the goals of providing trauma-informed approaches and reducing re-traumatization. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides direction in implementing trauma-informed approaches across 10 organizational domains in its publication, "Concept of Trauma and Guidance for a Trauma-Informed Approach." Those domains are: governance and leadership, policy, physical environment, engagement and involvement, cross-sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing, and evaluation.[36]
- Implement resiliency-building and trauma informed educational and behavioral approaches in schools and early childhood settings (e.g., Montana Behavioral Initiative, social-emotional learning practices, and restorative rather than punitive disciplinary practices).
- Promote the use of early childhood home visitation programs, as recommended by the Community Preventive Services Task Force and based on strong evidence of effectiveness in reducing child maltreatment among high-risk families. Home visitation to prevent violence includes programs in which parents and children are visited in their home by nurses, social workers, paraprofessional and community peers. Visits must occur during the child's first two years of life, but they may be initiated during pregnancy and may continue after the child's second birthday.[39]
- Increase awareness of and referrals to evidence-based early childhood home visitation programs among healthcare, human service, and other professionals.
- Develop and maintain a state-level resource to share information about ACEs and trauma-informed approaches (e.g., resources for various fields of practice, training and education opportunities, support for organization moving toward trauma-informed approaches, and resources for individuals, families, and communities).

ACEs Strategies Continued:

- Continue to support training and train-the-trainer initiatives addressing ACEs and trauma-informed approaches for health and human service providers, educators, early childhood service providers, schools, communities and other organizations, including those provided by the DPHHS, ChildWise Institute, Elevate Montana, and the National Native Children's Trauma Center.
- Screen for ACEs and trauma among high-risk parents and children using age-appropriate and setting -specific screening tools, as recommended in professional guidelines for various disciplines. When results are positive, assure appropriate referrals and follow-up services.
- Promote the use of group and individual cognitive-behavioral therapy for symptomatic youth who have been exposed to traumatic events, as recommended by the Community Preventive Services Task Force based on strong evidence of effectiveness in reducing psychological harm.[39]
- Promote the use of evidence-based clinical interventions included in the Substance Abuse and Mental Health Services Administration National Registry for Evidence-Based Programs. This registry includes 14 evidence-based interventions that are targeted to specific populations and/or settings.[34]
- Implement strategies described in this plan to mitigate the health consequences of ACEs/trauma which include increased prevalence of chronic disease; increased risk for depression, mental illness, substance use disorders and suicide attempts; early initiation and continued misuse into adulthood of alcohol, tobacco and other drugs; and increased prevalence of high risk sexual behaviors.
- Continue to collect and analyze data to monitor the burden of and progress toward reducing ACEs and trauma in Montana (e.g., data regarding the prevalence of ACEs, the extent to which training and education regarding ACEs is being provided, implementation of trauma-informed approaches, and provision of home visitation services).

Studies have shown an association between ACEs and chronic diseases, behavioral health issues, and initiation of risky health behaviors.

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Appendix A: Development and Implementation of the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP)

The PHSD established the State Health Improvement Coalition in 2017. The goal of this coalition is to support DPHHS in the development, implementation, and monitoring of the 2019–2023 SHA and SHIP. The SHA describes the current population-level health status of Montanans. It includes multiple quantitative data sources (e.g., birth and death records, hospitalization data, Behavioral Risk Factor Surveillance System, and Youth Risk Behavioral Surveillance System data) that describe the health status of Montanans. In addition, the SHA also includes summarized qualitative data compiled from the 52 local community health assessments and community health improvement plans completed by local and tribal health departments and the community health needs assessments completed by hospitals across Montana. The coalition used this information to identify and prioritize the health improvement areas, goals, strategies, and objectives described in this plan. In addition to the work of the SHIP coalition, the findings from the SHA and the proposed SHIP priority areas were presented to multiple stakeholder and partner groups who provided valuable feedback on the assessment and the plan.

Appendix B: Acknowledgements

We would like to thank those groups and agencies that were involved in developing and providing feedback on the State Health Assessment and State Health Improvement Plan:

- Addictive and Mental Disorders Division, Department of Public Health and Human Services
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- Cascade City-County Health Department
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- Helena Indian Alliance
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- Lincoln County Health Department
- Montana Association of Counties
- Montana Chapter of American Academy of Pediatrics
- Montana Department of Environmental Quality
- Montana Diabetes Coalition
- Montana Environmental Health Association
- Montana Healthcare Foundation
- Montana Hospital Association
- Montana Medical Association
- Montana Pharmacy Association
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How to use the State Health Improvement Plan

Top five health issues

The five issues addressed in the State Health Improvement Plan are:

- Behavioral Health
- Chronic Disease Prevention and Self-Management
- Motor Vehicle Crashes
- Healthy Mothers, Babies, and Youth
- Adverse Childhood Experiences (ACEs)

The 2019-2023 State Health Improvement Plan (SHIP)

The SHIP is an action-focused 5-year plan to address key health issues and improve the health and well-being of Montanans. Groups across Montana are working together to improve behavioral, maternal, and child health and reduce chronic disease and motor vehicle crashes.

The SHIP is a tool for everyone. Here are some ways it can be used:

Read the SHIP. *Access a copy of the SHIP online using the website below. Does it match what you see in your community? Is your community or organization working on these health issues? How can you team up with partners in your area to work on them?*

Get involved. *Many local and tribal health departments lead efforts to identify health issues and make plans to improve health. Be a champion for community health planning; contact your local or tribal health department to learn about their work and ask how you can participate.*

Align plans or policies. *Ask local government, businesses, schools, non-profits, and other groups to align their efforts with the key health issues in the SHIP and to include the SHIP in their planning documents and policies. It will take everyone working together to successfully improve the health of Montanans.*

Tell us how you are using the SHIP with the "A Healthier Montana" comment box at https://dphhs.mt.gov/ahealthiermontana.

CONTACT
Anna Bradley
Plans Coordinator
(406) 444-5968
abradley@mt.gov

RESOURCES

For more information and to download the SHIP, visit the A Healthier Montana website at https://dphhs.mt.gov/ahealthiermontana. You'll also find:

The 2017 State Health Assessment (SHA), a report about the overall health of Montanans.

Additional statewide health improvement plans, such as the Comprehensive Cancer Control Plan, the Montana Suicide Prevention Plan, and more.


MONTANA
DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Montana Substance Use Disorder Task Force Strategic Plan

Introduction

Substance use is an ongoing concern in the state of Montana, affecting individuals and families across the lifespan. This plan, the second of its kind in our state, outlines strategic actions that partners in Montana will take to collectively address the issue of substance use from a public health perspective.

More than 100 people die every year from drug overdose in Montana. and more than 15,000 emergency department visits annually are attributable to substance use.[1] The impacts of substance use span every generation and cut across socioeconomic lines, from children in our foster care system, to adults in our correctional facilities, to seniors prescribed opioids for chronic pain.

Partners across our rural state have collaborated under a shared strategic plan to develop more robust, evidence-based systems to prevent, treat, and manage substance use disorders (SUD) in Montana since 2017. With tens of thousands of individuals in our state impacted by this issue, we must continue to work collectively to implement the strategies under this updated plan to make further progress.

This plan outlines a series of targeted strategies in six key areas that Montanans can implement to lessen the impact of substance use in our state.

- Partnerships
- Surveillance and Monitoring
- Prevention
- Treatment and Recovery
- Harm Reduction
- Enforcement and Corrections

The Montana Substance Use Disorder Task Force Strategic Plan initially focused on the epidemic associated with prescription and illicit opioid use in Montana. While the current strategic plan does not focus on all areas of SUD, the Task Force continues to expand its focus more broadly on other SUD related issues (e.g. methamphetamine). The framework covered through the six focus areas described above is relevant for addressing other SUDs. If you have questions about this plan, contact the DPHHS Injury Prevention Program at their website below.

Letter from the Governor

Montanans are committed to helping individuals and families affected by opioid substance use reclaim their lives and get on a path to recovery.

An estimated 79,000 Montanans struggle with substance use disorders, the impacts of which reverberate through families and communities across our state. Drug overdoses are the fourth leading cause of injury-related death in Montana, accounting for 1,437 deaths from 2007-2018, and Montanans aged 35-54 years have the highest rate of drug poisoning deaths. Though Montana has bucked national trends with sustained declines in opioid overdose deaths in recent years, hundreds of thousands of Montanans continue to be affected by substance misuse and abuse.

At the start of our last strategic plan addressing substance use disorders in the state, the national average for opioid overdose deaths mirrored that of Montana: 5.5 deaths per 100,000 to Montana's rate of 5.4 deaths per 100,000. **Now, at the launch of the second iteration of the strategic plan, the state opioid overdose rate has fallen to 2.7 deaths per 100,000. Compared to the national opioid overdose rate of 22.8 deaths per 100,000, Montana is strategically situated to continue successfully addressing this crisis, but we understand that now is not the time to be complacent in our efforts.**

Our state's coordinated efforts to fight the substance use epidemic have helped to protect the lives of our citizens. Under the strategic taskforce and state strategic plan since 2016, we have created strong partnerships between local, tribal and state health and justice partners. We have improved our systems for helping affected individuals access treatment and sustain recovery. We have expanded surveillance and improved data collection to ensure real time monitoring of the crisis and rapid public health response. We have expanded access to drug treatment courts and evidence-based care while promoting harm reduction and appropriate justice system diversion. Between the work of the Montana Substance Use Disorders Taskforce and the recent directive to make federal opioid funding available to work in the fight of stimulants, I am confident we can continue to make progress to reduce the impact of overdoses in our great state.

I have continued to fight for Medicaid expansion, which helps to provide additional coverage for the treatment of substance use disorders. Access to care is critical, and without the expansion, some of our populations most vulnerable would be left without the resources to access affordable health coverage.

This state strategic plan, now in its second iteration, continues to be supported and adapted by the Montana Substance Use Disorders Taskforce, which is made up of more than 250 individuals representing over 135 organizations. This Taskforce is comprised of a wide variety of stakeholders, including medical professionals, law enforcement, public health and education, state agencies, and non-profit workers. Together, they continue to work toward a healthy and safe Montana.

Sincerely,

STEVE BULLOCK
Governor

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PARTNERING TO ADDRESS SUBSTANCE USE IN MONTANA

THIS UPDATED STRATEGIC PLAN WAS DEVELOPED WITH PARTNERS ACROSS OUR STATE.

The Montana Department of Public Health and Human Services (DPHHS) first convened the Montana Substance Use Disorders (SUD) Taskforce with funding from the Centers for Disease Control and Prevention's Data Driven Prevention Initiative in the fall of 2016. The taskforce, which meets four times per year, has engaged a total of 250 individuals representing 135 organizations statewide. In the spring of 2017, the MT SUD Taskforce published its first strategic plan for addressing substance use in our state.

Operating under this plan from 2017-2019, Montana implemented numerous strategies to improve systems for preventing, treating, and tracking SUDs statewide. Under this plan, DPHHS engaged justice system, community and health partners and developed data sharing agreements for tracking the opioid epidemic and SUDs more broadly in our state. From 2017-2019 the number of providers waivered to prescribe buprenorphine for the treatment of opioid use disorders in Montana grew from less than 20 to 150, and nearly 1,000 additional medical providers began accessing the prescription drug registry each month. In 2019, legislation was passed mandating use of the prescription drug registry, requiring identification to pick up opioid prescriptions, and limiting first time opioid prescriptions to a seven-day supply. Bucking national trends, Montana's opioid overdose death rate declined from 7.4 deaths per 100,000 in 2009-2010 to 2.7 deaths per 100,000 in 2017-2018.[1]

In the fall of 2019, Montana received three years of additional funding through a cooperative agreement with the CDC's Overdose Data to Action (OD2A) initiative to continue to implement activities to reduce overdose deaths in Montana. The focus areas for OD2A are:

- Increased timeliness and accuracy of surveillance data to improve drug overdose intervention.
- Greater awareness of opioid and other drug overdoses within the state, leading to increased preparedness and response at the local and state level.
- Decreased high-risk opioid prescribing while increasing education to those receiving opioid prescriptions (both opioid-naïve and legacy patients) and increasing access/use of non-opioid and non-pharmacologic treatments of pain.
- Improved utilization of evidence-based prevention, intervention, and referral to treatment at the local and state level.

Utilizing this funding, DPHHS worked with Taskforce partners to update the strategies for addressing substance use in our state. Through a number of participatory sessions in late 2019 and early 2020, SUD Taskforce members prioritized the strategies that are included in this updated plan. As a western state heavily impacted by methamphetamine use, we have advocated for a holistic focus for this plan which will improve the system for preventing, tracking and treating all SUDs impacting Montanans. New federal guidelines allow us to direct funds to address stimulant use as well as opioids. Working together, we will continue to reduce the negative health impacts of opioids and other drugs in our state.

Key Accomplishments

Under the first Addressing Substance Use Disorders strategic plan from 2017-2019, Montana partners made major strides to reduce the overall burden of opioid overdose in the state. Major accomplishments under the first plan include:

Partnerships

- The Montana Substance Use Disorders Taskforce engaged over 250 partners from organizations and agencies across the state
- More than $30 million of federal funding was secured by partners to address opioid use in Montana
- Montana created an epidemiologic workgroup focused on substance use disorders and analyzed justice system and prescription drug registry data that had not been previously available

Prevention and Education

- We awarded 35 mini-grants to local communities to support evidence-based prevention activities such as education for youth and drug take back events
- 100,000 Deterra bags for safe opioid disposal were distributed across all Montana counties and the number of medication drop boxes grew to 164
- 1,600 units of Naloxone, the life-saving opioid overdose reversal drug, were dispensed
- New legislation now limits first time opioid prescriptions and requires identification for opioid prescription pick up

Enforcement

- The number of active drug court participants grew 25%
- The Department of Corrections secured federal funding to develop a plan to implement Medication Assisted Treatment in its detention facilities

Monitoring

- The number of providers registered with the Montana Prescription Drug Registry (MPDR) grew from 3,898 to 4,785
- The number of monthly searches using the registry grew from 26,274 to 34,970
- Montana passed legislation mandating the use of the MPDR

Treatment

- The number of medical providers with buprenorphine waivers grew from 38 to 143, greatly expanding access to evidence-based opioid use disorder treatment
- Bolstered by Medicaid expansion funding and new federal and foundation grants, providers across the state began implementing evidence-based Integrated Behavioral Health Care and Opioid Use Disorder Treatment programs
- The number of naloxone master trainers grew from 0 to 530

Family and Community Resources

- The number of safe syringe programs in Montana quadrupled from 2 to 8
- Partners like the Montana Healthcare Foundation's Meadowlark Initiative sought to increase access to substance use treatment for pregnant women and mothers

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Substance Use in Montana

An estimated 79,000 Montanans have a substance use disorder[7]

Methamphetamine

44% of all open Child and Family Services placements have meth indicated.[3]

100% increase in meth violations from 2014-2018.[4]

35% of all drug violations are for meth.[4]

Marijuana

21% of high school students report marijuana use in the last month.[5]

53% of Montana youth perceive smoking marijuana regularly as risky.[6]

171K Estimated number of Montanans aged 12+ using marijuana in the last year.[7]

44% of all drug violations are for marijuana.[4]

Alcohol

64K Montanans aged 18+ have a current alcohol use disorder.[7]

1 in 3 high school students report alcohol use in the last month.[5]

18% of Montana adults report binge drinking in the last year.[8]

43% of all traffic fatalities in Montana are attributable to alcohol impaired driving.[9]

390 alcohol attributable deaths annually.[1]

Other Illicit drugs

31K Montanans used illicit drugs other than marijuana in the last year.[7]

570 heroin/opioid arrests in Montana in 2018, up from 4 in 2005.[4]

6% of young adults aged 18-25 report using cocaine in the last year.[7]

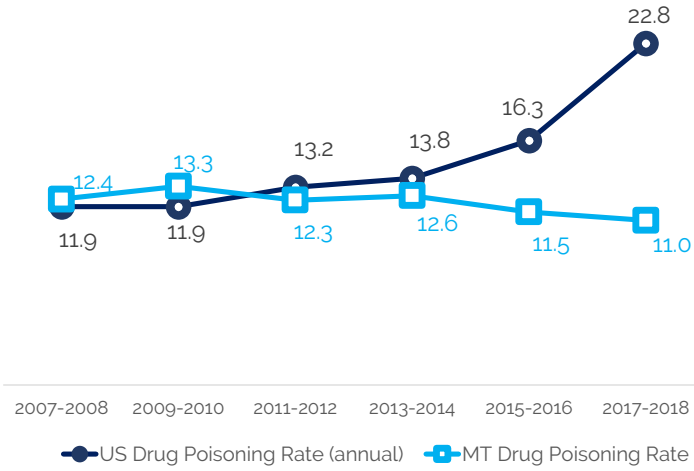
92% of Montanans with a Substance Use Disorder are not receiving treatment.[7]

Opioid Use in Montana

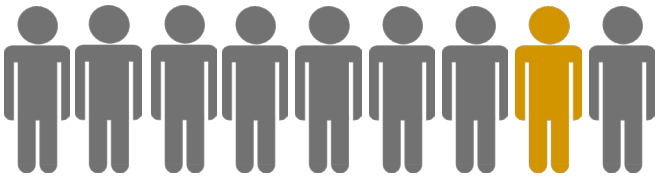
Opioid use is the primary driver of drug overdose deaths in the state of Montana. Thirty-five percent of all drug overdose deaths are attributable to opioids.[10] Montana has made progress in recent years addressing prescription opioid misuse and abuse and reducing overdose deaths, though much more can be done to ensure that opioids are prescribed, taken, and disposed of safely and that patients being transitioned off of high dose prescription opiates do not transition to illicit narcotics such as heroin and fentanyl.

Montana has 89 opioid prescriptions for every 100 residents.[11]

The drug poisoning death rate in Montana has fallen in recent years, bucking national trends.[10]



The rate of opioid overdose deaths in Montana peaked in 2008-2009 and has decreased significantly while the US rate has skyrocketed. The Montana opioid overdose rate was 2.7 per 100,000 residents in 2017-2018.[10]



One in nine high school students has misused prescription drugs.[5]

Between 2006-2018, more than 600 Montanans died from opioid overdose.[10]

Strategic Plan Overview

Overall goal

Reduce drug related morbidity and mortality across all populations in Montana

Focus Areas

- Partnerships
- Surveillance and Monitoring
- Prevention
- Treatment and Recovery
- Harm Reduction
- Enforcement and Corrections

Overall Metrics

- Decrease mortality due to all drug overdoses
  - ▼ 11 deaths per 100,000 Montanans (2017-2018)[1]
- Decrease hospitalizations due to drug overdoses
  - ▼ 920 drug cases per 100,000 admissions (2018)[2]
- Decrease emergency department visits due to drug overdoses
  - ▼ 621 drug cases per 100,000 ED visits (2018)[2]

Criteria for strategies included in this plan

- Evidence based & data driven
- Sustainable
- Realistic & achievable
- Comprehensive
- Multidisciplinary
- Trauma informed
- Empowers at-risk groups

Partnerships

Focus Area One

Metrics

- Regularly convene Substance Use Disorder Taskforce
  Target | 4 meetings per year
- Regularly convene State Epidemiologic Outcomes Workgroup
  Target | 10 meetings per year

Key Area for Action

1.1 Cross sector collaboration

Strategies & Leads

1.1.1 Support cross sector collaboration between SUD stakeholders statewide

- Montana Substance Use Disorders Taskforce **Lead |** OD2A

1.1.2 Strengthen partnerships between system leaders

- SUD Epidemiologic Outcomes Workgroup **Lead |** OD2A, OESS, AMDD
- Bi-Monthly Meetings with Opioid Grantees **Lead |** OD2A

1.1.3 Foster relationships between health and justice system partners

- Comprehensive Opioid Abuse Program (COAP) Grant **Lead |** Montana Department of Corrections (DOC)
- Engage probation and parole, Montana Board of Crime Control in the SUD Taskforce **Lead |** OD2A
- Develop relationships with juvenile justice system partners **Lead |** OD2A

Key Area for Action

1.2 Engage diverse partners

Strategies & Leads

1.2.1 Coordinate with local and tribal efforts to address SUDs

- **Leads |** Local behavioral health and prevention coalitions, local and tribal health departments, Montana Tribal Leaders, Chamber of Commerce, MSU Extension Grant, Montana Association of Counties, OD2A Mini-Grants

1.2.2 Learn from individuals with lived experience

- At least one panel per year at the SUD Taskforce **Lead |** OD2A

1.2.3 Better support children and young families affected by SUDs

- **Leads |** DPHHS Early Childhood and Family Support Division (ECFSD) , Healthy Mothers Healthy Babies (HMHB), Medicaid, Montana Head Start Association (MTHSA) and DPHHS Head Start Collaboration Office

Surveillance and Monitoring

Focus Area Two

Metrics

Decrease rate of opioid prescriptions

Baseline | 89 opioid prescriptions (excluding buprenorphine) per 100 Montanans (2017)[11]

Baseline | Mean daily MME: 49.7 (2017)[11]

Increase number of datasets analyzed

Baseline | 14 datasets (2019)

Key Area for Action

2.1 Data sharing

Strategies & Leads

2.1.1 Establish data sharing agreements with internal and external partners

- **Lead |** OD2A

2.1.2 Maintain and strengthen existing data sharing

- Continue agreements with DOC/Local Law Enforcement and Detention Facilities, PDMP, Medicaid, Rocky Mountain Tribal Leaders Council Epidemiology Center and others. **Lead |** OD2A

2.1.3 Support effective data collection and evaluation for local SUD projects

- **Leads |** OD2A, SUD Epidemiological Workgroup, HMHB Child Health Data Partnerships, Safe Syringe Programs, Community Health Assessments

Key Area for Action

2.2 Analysis and Communication

Strategies & Leads

2.2.1 Analyze datasets

- BRFSS, YRBS, and PNA
- State Unintentional Overdose Reporting System (SUDORS)
- Montana Prescription Drug Registry
- Vital statistics, Hospital Discharge, Emergency Department visits
- Naloxone use tracking—ImageTrend and Law Enforcement

2.2.2 Publish surveillance reports on substance use trends regularly

- Technical report and reports designed for consumption by the general public **Lead |** OD2A

Key Area for Action

2.3 Monitoring

Strategies & Leads

2.3.1 Transition to a new Prescription Drug Registry (PDR) platform

- Create advisory board to vet vendors, review potential systems, and guide transition to new registry and select platform with increased functionality and enhanced data fields **Lead |** Board of Pharmacy

2.3.2 Regularly share de-identified PDR data with DPHHS **Lead |** Board of Pharmacy

2.3.3 Support robust utilization of the MPDR to improve prescribing practices

- Provide education and training to providers about the new PDR functionality and how to utilize it to track and improve care **Leads |** OD2A, Department of Justice, Montana Medical Association, Montana Hospital Association, Montana Pharmacy Association
- Support implementation and education on new Montana legislation mandating MPDR use and restricting length of first opioid prescription starting in 2021 **Leads |** OD2A, Department of Justice, Montana Medical Association, Montana Hospital Association, Montana Pharmacy Association
- Support integration of the new MPDR into EHRs and pharmacy operating systems **Leads |** Board of Pharmacy, OD2A

2.3.4 Expand use of Academic Detailing to monitor morphine milligram equivalents

- **Leads |** Medicaid, Mountain Pacific Quality Health, Veteran's Administration

Prevention

Focus Area Three

Metrics

Decrease youth substance use[5]

Baseline, for Montana high school students |

- Lifetime pain prescription misuse: 12.8% (2019)
- Alcohol use, past 30 days: 33% (2019)
- Marijuana use, past 30 days: 21% (2019)
- Electronic vapor product use, past 30 days: 30% (2019)

Key Area for Action

3.1 Local prevention infrastructure

Strategies & Leads

3.1.1 Increase capacity and training opportunities for Local Prevention Specialists

- Support the certification of prevention specialists **Lead |** AMDD, OD2A and Youth Connections

3.1.2 Support local prevention coalitions to implement evidence-based programs

- Communities that Care **Lead |** Montana Healthcare Foundation, AMDD
- Drug Free Communities Grants **Lead |** AMDD
- Substance Abuse Block Grant **Lead |** AMDD
- Partnership for Success Grant **Lead |** AMDD
- Mini-grants to support local coalition work **Lead |** OD2A
- Train rural communities on opioid misuse education and safe disposal **Lead |** MSU Extension

3.1.3 Enhance capacity of tribal communities to design and implement culturally appropriate prevention activities

- **Leads |** Indian Health Service, Tribal Health Departments, Medicaid Tribal Health Improvement Program, Tribal Opioid Response Grants, and Strategic Planning, OD2A Mini-grants-OD2A

Key Area for Action

3.2 Awareness and stigma reduction

Strategies & Leads

3.2.1 Educate on opioid prescription storage and disposal

- Increase drop boxes and maintain prescription drop boxes map **Leads |** Department of Justice, local law enforcment agencies, AMDD
- Law enforcement drug take back events **Leads |** DEA and local law enforcement, Department of Justice
- Education for older adults **Lead |** AMDD

3.2.2 Educate providers on evidence-based prescribing practices

- Trainings using telehealth or online platforms
  - Know Your Dose **Lead |** Montana Medical Association
  - Mini-grants **Lead |** OD2A
  - Opioid Use Disorder Project Echo **Lead |** Billings Clinic
- In-person trainings
  - Buprenorphine waiver trainings **Lead |** Montana Primary Care Association
  - Montana Pain Conference **Lead |** Western Montana Area Health Education Center
  - Opioid Misuse in Rural Montana **Lead |** MSU Extension

3.2.3 Educate communities and promote stigma reduction initiatives

- Parenting Montana Website **Lead |** AMDD. MSU Bozeman
- Stigma and Education Campaign **Lead |** OD2A, HMHB, Open Aid Alliance
- Initiative to reduce stigma for seeking treatment for pregnant women and mothers **Lead |** HMHB
- Aid Montana **Lead |** Department of Justice
- OD2A Mini-grants **Lead |** OD2A
- Meadowlark Initiative **Lead |** Montana Healthcare Foundation, local health organizations

Key Area for Action

3.3 Adverse Childhood Experiences (ACEs) and Resiliency

Strategies & Leads

3.3.1 Provide training on ACEs, trauma informed practices, and resiliency

- Increase the number of ACE Master Trainers and ACE trainings **Lead |** Elevate Montana
- Train the trainer model for trauma-informed criminal justice responses **Lead |** SAMHSA GAINS Center
- Trauma informed care training for tribal providers **Lead |** Billings Area IHS, Mountain Pacific Quality Health
- Train early chilhood educators and medical providers **Lead |** DPHHS ECFSD, MTHSA

3.3.2 Implement mental health consultation services in early childhood settings

- Support for increased funding and training on the model **Lead |** DPHHS ECFSD

3.3.3 Develop a train-the-trainer model for 0-3 Infant-toddler mental health for Montana behavioral health professionals

- **Lead |** DPHHS ECFSD

3.3.4 Expand bi-directional referral networks for children and families experiencing trauma and behavioral health concerns

- Support use of the CONNECT referral system in early childhood settings **Lead |** OD2A
- Expand referral networks and partnerships to increase access to SUD treatment for pregnant mothers and engage medical providers in identifying where outreach/education support is needed **Lead |** Montana Healthcare Foundation, HMHB

3.3.5 Support the work of local coalitions focused on early childhood and ACEs

- **Lead |** Early Childhood Coalitions, Headwaters Zero to Five Initiative, OD2A

3.3.6 Implement prevention initiatives in schools and early childhood settings

- PAX Good Behavior Game **Lead |** Office of Public Instruction and AMDD

3.3.7 Develop curriculum for working with young children affected by SUDs

- **Lead |** Montana Head Start Association, Montana University System

3.3.8 Implement "Handle with Care" program statewide to support trauma impacted youth **Lead |** DPHHS ECFSD, ChildWise, law enforcement, and other partners

3.3.9 Support advocacy efforts on behalf of at-risk young children and families.

- **Lead |** HMHB, Early Childhood Coalitions, MTHSA

Treatment and Recovery

Focus Area Four

Metrics

- Increase annual adult and youth client admissions to state-approved substance use treatment providers
  Baseline | 8,133 (2019)[12]
- Increase providers with a waiver to prescribe buprenorphine
  Baseline | 155 (February, 2020)[13]
- Increase patients treated for SUD at community health centers
  Baseline | 1,819 (2018)[14]
- Increase buprenorphine-waivered providers at HRSA health centers
  Baseline | 48 (2018)[14]
- Increase patients receiving MAT through HRSA health centers
  Baseline | 187 (2018)[14]

Key Area for Action

4.1 Linkage to care

Strategies & Leads

4.1.1 Expand the CONNECT Referral System to treatment and recovery systems

- Fund additional local CONNECT coordinators **Lead |** DPHHS and OD2A

4.1.2 Increase the use of 211 for self-referral

- **Lead |** Local United Way affiliates, Local Advisory Councils

4.1.3 Engage colleges and universities to increase SUD-related referrals for students

- Provide localized trainings and technical assistance **Lead |** OD2A, Montana University System

Key Area for Action

4.2 Access to treatment

Strategies & Leads

4.2.1 Advocate for robust insurance coverage

- Encourage private payers and Medicaid to cover the full continuum of care and alternative pain treatments **Lead |** Montana Hospital Association, Patient advocacy groups

4.2.2 Support workforce development to enhance provider coverage statewide

- Reduce barriers to LAC credentialing **Lead |** MPCA Behavioral Health Licensing Discussion Group
- Support dual licensed and waivered providers, especially in rural communities **Lead |** Universities, AMDD, MPCA

4.2.3 Increase the use of universal assessments for SUDs

- S-BIRT **Lead |** Montana Healthcare Foundation

4.2.4 Bolster the number of providers offering Integrated Behavioral Health services

- **Lead |** MTHCF, MPCA, Behavioral Health Alliance of Montana

4.2.5 Increase access to evidenced-based care including Medication for Addiction Treatment (MAT)

- Linkages to addiction service utilizing technology as needed **Lead |** SOR Grant
- Increase number of MAT-waivered providers **Lead |** SOR Grant, AMDD, MPCA
- Implement Targeted Capacity Expansion Grant **Lead |** MAT-PDOA
- Education on MAT and other evidence-based practices **Lead |** MPCA

4.2.6 Increase the number of full service Opioid Treatment Programs

- Support the Montana Chemical Dependency Center to offer all forms of MAT **Lead |** AMDD
- Expand access to methadone through OTPs across Montana **Lead |** AMDD, local providers

4.2.7 Expand access to family centered and culturally appropriate treatment

- Support initiatives targeting pregnant women and parents **Lead |** Meadowlark Initiative, local providers
- Support implementation of the Safe Harbor Policy for pregnant women seeking treatment **Lead |** DOJ
- Provide training on perinatal mood disorders and additional post-partum mental health care resources **Lead |** HMHB
- Champion culturally appropriate care **Leads |** Urban Indian Clinics, IHS, Tribal Health Departments
- Support provision of behavioral health services according to the Culturally and Linguistically Appropriate Services standards. **Lead |** AMDD

Key Area for Action

4.3 Access to recovery and support services

Strategies & Leads

4.3.1 Foster access to recovery support groups in all communities

- **Lead |** Narcotics Anonymous and Alcoholics Anonymous, local recovery groups, faith communities

4.3.2 Increase access to and training for certified peer support specialists

- **Lead |** Montana's Peer Network, Rocky Mountain Tribal Leaders Council, AMDD, NAMI

4.3.3 Support development of Addiction Recovery Teams in local communities

- **Lead |** AMDD in partnership with local providers

4.3.4 Increase funding and support for effective case management and recovery management strategies for individuals in treatment and recovery

- **Lead |** DPHHS, private payers, Medicaid

4.3.5 Expand access to safe, affordable Recovery Housing

- **Lead |** AMDD

4.3.6 Increase access to low cost community events that are drug and alcohol free

- **Leads |** Local recovery groups, city councils and governments, Early Childhood Coalitions

Harm Reduction

Focus Area Five

Metrics

- Increase number of safe syringe programs
  Baseline | 8 (2019)[15]
- Increase the number of naloxone units distributed annually
  Baseline | 1,283 (2018)[16]
- Increase the number of naloxone master trainers
  Baseline | 538 (September 2019)[16]

Key Area for Action

5.1 Naloxone

Strategies & Leads

5.1.1 Provide online and in-person naloxone training statewide

- Target EMS, fire, law enforcement, school nurses, libraries, homeless shelters, and individuals who use or associate with people using opioids **Lead |** SOR grant, DPHHS EMS and Trauma Program, AMDD

5.1.2 Establish a master naloxone trainer in every Montana county

- **Lead |** SOR grant, EMS and Trauma, AMDD

5.1.3 Place naloxone in Automated External Defibulater kits and provide training

- **Lead |** DPHHS EMS and Trauma Systems

5.1.4 Encourage co-prescribing of naloxone with opioids

- **Lead |** MMA, Medicaid, Mountain Pacific Quality Health, Montana Primary Care Association

5.1.5 Encourage initiation of MAT in patients who receive naloxone

- **Lead |** MMA, Medicaid, Mountain Pacific Quality Health

5.1.6 Encourage naloxone distribution by pharmacies utilizing the state standing order

- **Lead |** MMA, Medicaid, Mountain Pacific Quality Health

5.1.7 Develop systems to better track naloxone use, especially for law enforcement

- **Lead |** OD2A

Key Area for Action

5.2 Safe syringe programs

Strategies & Leads

5.2.1 Support and raise awareness about existing safe syringe programs
- **Lead |** DPHHS HIV/STD Section, OD2A Mini-grants

5.2.2 Advocate for additional safe syringe programs and funding in Montana
- **Lead |** DPHHS HIV/STD Section, existing local programs

5.2.3 Utilize safe syringe programs for distribution of naloxone and linkages to care
- **Lead |** AMDD SOR Grant

5.2.4 Increase HIV and Hepatitis C testing and treatment for injection drug users
- **Lead |** DPHHS HIV/STD Section

5.2.5 Support paraphernalia amendment legislation
- Focus on benefits of increasing needle disposal and protecting public health **Lead |** Open Aid Alliance

Key Area for Action

5.3 No or low barrier housing

Strategies & Leads

5.3.1 Support the development of low barrier shelters for individuals with SUDs
- **Lead |** Montana Continuum of Care Coalition

5.3.2 • Support local Coordinated Entry system for linkage to housing resources
- **Lead |** HUD, Montana Continuum of Care Coalition

5.3.3 Develop Housing First programs to house individuals with SUD
- **Lead |** Montana Healthcare Foundation, local housing grantees and partners

5.3.4 Advocate for a Medicaid benefit for permanent supportive housing
- **Lead |** Montana Healthcare Foundation

Enforcement and Corrections

Focus Area Six

Metrics

- Increase number of treatment courts statewide
  Baseline | 37; 8 are tribal (2017)[17]
- Reduce relative risk of overdose mortality for Montanans recently released from a DOC facility
  Baseline | 27x more likely than average Montanan to die from overdose (2019)[18]
- Increase number of justice system facilities that offer MAT
  Baseline | Obtain from jail survey

Key Area for Action

6.1 Reduce supply

Strategies & Leads

- 6.1.1 Support local Drug Taskforces
  - **Lead |** Federal High Intensity Drug Taskforce Area funding, DOJ Division of Criminal Investigation
- 6.1.2 Enhance use and reach of Criminal Interdiction Teams
  - **Lead |** Montana DOJ
- 6.1.3 Train and employ additional Drug Recognition Experts
  - **Lead |** Montana Highway Patrol, local law enforcement agencies
- 6.1.4 Support the work of the Pill Diversion Agents
  - **Lead |** DOJ Division of Criminal Investigation

Key Area for Action

6.2 Crisis response and diversion

Strategies & Leads

6.2.1 Support communities to better understand and design their behavioral health crisis services through Sequential Intercept Mapping and other planning efforts

- **Lead |** Montana Healthcare Foundation, County Crisis Grants through AMDD

6.2.2 Support development of systems that appropriately divert individuals with SUD away from the justice system and into treatment

- Community agreements between law enforcement, SUD providers, and crisis response
- Mobile crisis response teams
- Co-responder models
- Clinically managed withdrawal management
- Short term crisis stabilization facilities
- Crisis Intervention Training and Mental Health First Aid training for Law Enforcement and first responders
- Empath Units
- System navigation and follow-up using peer support specialists and case managers
- **Leads |** County Matching and Mobile Crisis Grants through AMDD, Montana Healthcare Foundation, Local Advisory Councils, and other community coalitions

6.2.3 Advocate for more robust crisis funding in Montana

- Enhance federal, state, and local funding sources
- **Lead |** Montana Healthcare Foundation, County Crisis Grants through AMDD

Key Area for Action

6.3 Treatment Courts

Strategies & Leads

6.3.1 Increase access to and diversity of courts statewide, including robust family treatment court models

- **Lead |** Montana Judicial Branch

6.3.2 Increase state and federal funding for drug treatment courts

- **Lead |** Department of Justice, Montana Judicial Branch, Montana Healthcare Foundation

Key Area for Action

6.4 Access to treatment in the justice system

Strategies & Leads

6.4.1 Develop a strategic plan for increasing access to treatment in detention facilities and prisons

- **Lead |** Montana Department of Corrections COAP Grant

6.4.2 Increase access to evidence-based SUD evaluations and treatment in jails and correctional facilities

- **Lead |** COAP and Residential Substance Abuse Treatment (RSAT) grants, local providers

6.4.3 Increase access to SUD assessment and treatment in community corrections

- Improve continuity of care for individuals released into the community from DOC facilities
- **Lead |** DOC, Probation and Parole, Medicaid

6.4.4 Increase collaboration, support, and funding between juvenile probation and adult probation and parole

- **Lead |** DOC. local law enforcement agencies

6.4.5 Increase access to recovery supports for individuals who are justice system involved

- **Lead |** COAP grant

6.4.6 Distribute naloxone to individuals with SUDs upon release from jail/prison

- **Lead |** SOR Grant and DOC

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References for Metrics

Page 10 || Substance Use in Montana

Montana Child and Family Services administrative data, 2018.

- 44% of all open Child and Family Services placements have meth indicated

Montana Statistical Analysis Center, Department of Corrections Crime Control Bureau. 2018 Crime in Montana Summary.

- 100% increase in meth violations from 2014-2018
- 35% of all drug violations are for meth
- 44% of all drug violations are for marijuana
- 570 heroin/opioid arrests in 2018, up from 4 in 2005

Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019.

- 21% of high school students report marijuana use in the last month

Montana Department of Public Health and Human Services, Prevention Needs Assessment. 2018.

- 53% of Montana youth perceive smoking marijuana once or twice a week as harmful to themselves (physically or in other ways)

SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

- An estimated 79,000 Montanans age 12+ have a substance use disorder
- 64,000 Montanans aged 18+ have a current alcohol use disorder
- 171,000 Montanans aged 12+ were estimated to have used marijuana in the last year
- 31,000 Montanans were estimated to use illicit drugs other than marijuana in the last month
- 6% of young adults aged 18-25 report using cocaine in the last year
- 92% of Montanans with a substance use disorder are not receiving treatment

Montana Department of Public Health and Human Services (MT DPHHS) and Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Helena, MT: Montana Department of Public Health and Human Services, Public Health and Safety Division, 2018.

- 18% of Montana adults report binge drinking in the last year

National Highway Traffic Administration. (2019). 2018 Fatal motor vehicle crashes: Overview.

- 43% of all traffic fatalities in Montana are attributable to alcohol-impaired driving

Page 11 || Opioid Use in Montana

Montana Department of Public Health and Human Services Injury Prevention Program, Drug Poisoning Deaths in Montana, 2007-2018.

- 35% of all overdose deaths are attributable to opioids
- The drug poisoning rate in Montana has fallen since 2010, bucking national trends
- The Montana opioid poisoning rate was 2.7 per 100,000 residents in 2017-2018

Montana Department of Public Health and Human Services Injury Prevention Program, Opioid Prescribing Practices in Montana, 2012-2017.

- Montana has 89 opioid prescriptions for every 100 residents

Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019.

- Over one in ten high school students has taken a prescription drug without a doctor's prescription

Montana Department of Public Health and Human Services, Montana Vital Statistics Analysis Unit, 2007-2018.

- Between 2006-2018, more than 600 Montanans have died from opioid overdose

Page 15 || Surveillance and Monitoring

Montana Department of Public Health and Human Services Injury Prevention Program, Opioid Prescribing Practices in Montana, 2012-2017.

- 89 opioids (excluding buprenorphine) per 100 Montanans
- 49.7 Mean daily MME

Page 17 || Prevention

Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019. .

- Youth lifetime pain prescription misuse: 12.8%
- Youth alcohol use, past 30 days: 33.4%
- Youth marijuana use, past 30 days: 21.1%
- Youth electronic vapor product use, past 30 days: 30.2%

Page 20 || Treatment and Recovery

Montana Medicaid and Substance Abuse Management Information System (SAMS), 2019

- 8,133 adult and youth client admissions annually to state-approved substance use treatment providers

SAMHSA, Center for Behavioral Health Statistics and Quality, Buprenorphine Practitioner Locator, 2020.

- 155 providers with an x-waiver for buprenorphine

HRSA, Health Center Program, Montana Data, 2018.

- 1,819 patients treated for SUD at HRSA health centers
- 48 buprenorphine-waivered providers at HRSA centers
- 187 patients receiving Medication-Assisted Treatment through HRSA health centers

Page 23 || Harm Reduction

Montana Department of Public Health and Human Services STD/HIV Program, Get Tested Montana!, 2019.

- 8 safe syringe programs

Montana Department of Public Health and Human Services Addictive and Mental Disorders Division, Internal Data, 2019

- 1,283 naloxone units distributed annually
- 538 Naloxone master trainers

Page 25 || Enforcement and Corrections

Montana Supreme Court Office of Court Administrator, Montana Drug Courts: An Updated Snapshot of Success and Hope, 2019.

- 37 treatment courts statewide; 8 are tribal

Montana Department of Public Health and Human Services and Montana Department of Corrections, Internal Data, 2019

- Montanans recently released from a DOC facility are 27x more likely to die from an overdose than the average Montanan

Acronyms

AI/AN	American Indian/Alaska Native
AMDD	Addictive and Mental Disorders Division (DPHHS)
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
COAP	Comprehensive Opioid Abuse Site grant
DCI	Division of Criminal Investigation (DOJ)
DEA	Drug Enforcement Administration
DOJ	Montana Department of Justice
DDPI	Data-Driven Prevention Initiative
DOC	Montana Department of Corrections
DPHHS	Montana Department of Public Health and Human Services
ECFSD	Early Childhood and Family Services Division (DPHHS)
DPHHS	Department of Public Health and Human Services
EMS	Emergency Medical Services
HMHB	Healthy Mothers Healthy Babies
IHS	Indian Health Service
LAC	Licensed Addiction Counselor
MAT	Medication for Addiction Treatment
MCDC	Montana Chemical Dependency Center (DPHHS)
MMA	Montana Medical Association
MPCA	Montana Primary Care Association
MPDR	Montana Prescription Drug Registry
MTHCF	Montana Healthcare Foundation
OD2A	Overdose to Action Grant
OTP	Opioid Treatment Program
PDMP	Prescription Drug Monitoring Program
PDR	Prescription Drug Registry
PNA	Prevention Needs Assessment
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SOR	State Opioid Response Grant
SUD	Substance Use Disorder
YRBS	Youth Risk Behavior Survey

MONTANA SUBSTANCE USE STRATEGIC TASK FORCE

Addressing Substance Use Disorders in Montana | 2020

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MONTANA DPHHS

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Department of Public Health & Human Services

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Evidence based services which use quality improvement monitoring to ensure optimum prevention outcomes.

Priority Type: SAP

Population(s): PP

Goal of the priority area:

In order to efficiently and effectively use resources dedicated to the prevention of substance abuse, AMDD is focusing efforts and programming on the implementation of evidence-based practices.

Strategies to attain the goal:

Provide training and technical assistance to prevention specialists on the Strategic Prevention Framework and the (6) CSAP categories for implementing strategies that are the "best fit" for each identified problem behavior. Implement the Prevention Plan(s) utilizing the CSAP strategies model (DOI, Education, Alternatives, Problem Identification, Community-Based, Environmental)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the percentage of CSAP categories for Information Dissemination to 20%, Education to 20%, Alternatives to 10%, Problem Identification to 10%, Environmental 10% and Community-Based Process to 30% by October 2025.

Baseline Measurement: 2020 Baseline Measurement: Information Dissemination: 25% Prevention Education: 14% Alternative Activities: 9% Problem Identification: 1% Community-Based Process: 46% Environmental: 5%

First-year target/outcome measurement: By 12/31/2022, Block Grant communities will increase to: Information Dissemination: 23% Prevention Education: 16% Alternative Activities: 9% Problem Identification: 4% Community-Based Process: 40% Environmental: 8%

Second-year target/outcome measurement: By 12/31/2023, Block Grant communities will increase to: Information Dissemination: 21% Prevention Education: 18% Alternative Activities: 10% Problem Identification: 6% Community -Based Process: 36% Environmental: 9%

Data Source:

Prevention Needs Assessment (PNA); Web Infrastructure for Treatment Services (WITS); Behavioral Risk Factor Surveillance System (BRFSS)

Description of Data:

The PNA provides county level data for youth aged, 13-19 years old. The WITS system provides the number or hours worked on each CSAP strategy by our Prevention Specialists throughout the allocated counties in Montana. The BRFSS survey provides us with data to support our priority for adult binge drinking.

Data issues/caveats that affect outcome measures:

The PNA depends on if schools are open and willing to participate, so sometimes we have data gaps, but we can usually measure our outcomes. The WITS system works well; however, there is a need for continuous updates for the software and in depth trainings for Prevention Specialists. The BRFSS survey serves it's purpose and we can usually depend on the data to measure our outcomes.

Indicator #: 2

Indicator: Increase the percentage of Evidence Based Practices, Programs, and Policies (EBPPP) implemented by Prevention Specialists that are evidenced based to 10% innovative; 20% promising and 70% effective by October 2025

Baseline Measurement: 2020 Baseline Measurement: Effective: 34% Promising: 11% Innovative: 55%

First-year target/outcome measurement: By 12/31/2022, Block Grant communities will increase EBPPP to: Effective: 50% Promising: 15% Innovative: 35%

Second-year target/outcome measurement: By 12/31/2023, Block Grant communities will increase EBPPP to: Effective: 60% Promising: 18% Innovative: 22%

Data Source:

Web Infrastructure for Treatment Services (WITS); Youth Risk Behavior Surveillance System (YRBSS); Prevention Needs Assessment (PNA); Behavioral Risk factor Surveillance System (BRFSS)

Description of Data:

WITS provides us with hours completed in each CSAP strategy, which includes the identified evidence level for each activity including, but not limited to, evidence based programs. YRBSS provides us with data regarding substance use among youth and it is implemented every odd year in schools. The PNA is offered every even year and provides us with substance use data among ages 13-19. The BRFSS survey provides us with the young adult and adult data regarding substance use.

Data issues/caveats that affect outcome measures:

Some of the data might not collect a significant participant rate, which results in data gaps for that county/community/school, etc.; however we can refer to a previous year, region percentage, or state percentage if we need a more significant and accurate representation of the data if data gaps happen.

Indicator #: 3

Indicator: All SABG Funded communities (33) implement a minimum of two local or regional policies that address youth alcohol and/or cannabis targets by 2025.

Baseline Measurement: 18 communities have implemented at least 1 local or regional policies as of 9/30/20.

First-year target/outcome measurement: 70% of communities will have implemented at least 1 local or regional policy that addresses youth alcohol and/or cannabis targets by 12/31/2022.

Second-year target/outcome measurement: 90% of communities will have implemented at least 1 local or regional policy that addresses youth alcohol and/or cannabis targets by 12/31/2023.

Data Source:

Web Infrastructure for Treatment Services (WITS); Youth Risk Behavior Surveillance System (YRBSS); Prevention Needs Assessment (PNA); Behavioral Risk factor Surveillance System (BRFSS); Web Panel Surveys through the Public Health Institute.

Description of Data:

WITS provides us with hours completed in each CSAP strategy, which includes the identified evidence level for each activity including, but not limited to, Environmental Approach with policy implementation. YRBSS provides us with data regarding substance use among youth and it is implemented every odd year in schools. The PNA is offered every even year and provides us with substance use data among ages 13-19. The BRFSS survey provides us with the young adult and adult data regarding substance use.

Data issues/caveats that affect outcome measures:

Some of the data sets might not be set up for marijuana specifically, as it has recently passed as a recreational approved drug for retail purposes; however the beginning phases of this new law provides us with the opportunity to implement policies in counties regarding the sale and use of marijuana.

Priority #: 2

Priority Area: A continuum of community-based mental and behavioral health services to improve support of pregnant women and women with dependent children.

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

To support programs to serve pregnant women and dependent children with effective clinical and wrap around services to improve long-term outcomes for the family.

Strategies to attain the goal:

Provide outreach to all state approved programs promoting access to SABG funding, training on services that SABG funds can cover to support women with children/pregnant women who have a substance use or co-occurring disorder.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: To increase the number of Substance Abuse Disorder (SUD) Treatment Programs that access SAMHSA Block Grant funds to support pregnant women and women with dependent children.

Baseline Measurement: Currently 41% of contracted State Approved SUD Treatment Providers utilize SABG funds for PWID.

First-year target/outcome measurement: By the end of FY2022 we will increase the number of SUD Treatment Programs that access block grant funds to serve pregnant women and women with dependent children by 20%

Second-year target/outcome measurement: By the end of FY2023, Montana will increase the number of SUD Treatment Programs that access block grant funds to serve pregnant women and women with dependent children by 30% (X).

Data Source:

Data can be measured by the number of proposals and contractors implementing Block Grant funds to support SUD treatment programs for pregnant women and women with dependent children.

Description of Data:

The data includes an assessment of programs being implemented for pregnant women and women with dependent children. The number of total State Approved treatment providers is 91. Of those, 22 receive SABG Funds and of these, 9 programs provided SABG funded services to Women with Dependents. Most of the SABG funds for PWID is to fund Room and Board for 6 Residential Treatment programs. These homes are:
Rimrock – Michele's House - Billings
Western Montana Addiction Services Carol Graham Home - Missoula
White Sky Hope – Women's Recovery Home – Rocky Boy Tribe
Gateway Community Services – Selene House – Kalispell
New Day – Braided Circle - Billings
Florence Crittenton Home – Teen and Adult pregnant women and women with dependent children - Helena

Data issues/caveats that affect outcome measures:

We will provide outreach to all contracted State Approved programs and encourage them to utilize SABG funds for parenting classes and other allowable support services for Women With Dependent Children and Pregnant Women. Additionally, we will encourage providers to identify clients receiving these services as a critical population in the SAMS data system.

Priority #: 3

Priority Area: A continuum of community-based behavioral health recovery and wellness support services to improve long-term recovery for individuals with substance use and co-occurring disorders.

Priority Type: SAT

Population(s): SMI, SED, PWWDC, ESMI, PWID, EIS/HIV

Goal of the priority area:

To support the training and implementation of WRAP facilitators using this evidence-base program to positively impact individuals in or working towards recovery and wellness.

Strategies to attain the goal:

Provide planning, training and support to mental health and behavioral health treatment service agencies to increase the number of WRAP facilitators trained in MT.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	To increase the number of trainers providing Wellness Recovery Action Plan (WRAP), a tool of peer support services to aid clients during treatment discharge and aftercare planning.
Baseline Measurement:	The number of current facilitators trained in WRAP currently serving clients. Current number is 0 (Sept 2021)
First-year target/outcome measurement:	By the end of FY2022 Montana will increase the number of WRAP facilitators trained by 10%, 10 Fascilitators.
Second-year target/outcome measurement:	By the end of FY2023, Montana will increase the number WRAP facilitators trained by 20%, 20 Fascilitators.

Data Source:

Calculating number of providers trained as WRAP Facilitators.

Description of Data:

Monitoring and tracking trained WRAP facilitators.

Data issues/caveats that affect outcome measures:

None

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

1/12/2022 - Knowing that TB is a critical population component and requirement for the Block Grant, per the revision, here is the information requested along with documents that have been uploaded in the Attachments section under Planning Tables.

As of 2020 there was a .4 incident rate per 1,000,000 Montanans that consisted of 4 females that year. 2021 data is currently not available.

All state approved providers must have updated policies and procedures in place to continue treatment while an individual is receiving treatment specific to TB. Providers are required to send referrals to public health and must follow up.

Montana's contracts with all state approved providers, include an Attachment F. Assurance of Compliance with Certain Requirements for Substance Use Disorders Treatment Service. Please see the document in the Attachments section under Planning Tables.

MONTANA COMMUNICABLE DISEASE EPIDEMIOLOGY

Tuberculosis Surveillance Update — Montana, 2020

This report reflects confirmed tuberculosis cases reported to the Montana Department of Public Health and Human Services (DPHHS) in 2020. This report was prepared by the Tuberculosis Program. Contact Ryan Weight at 406-444-0273 or ryan.weight@mt.gov with questions.

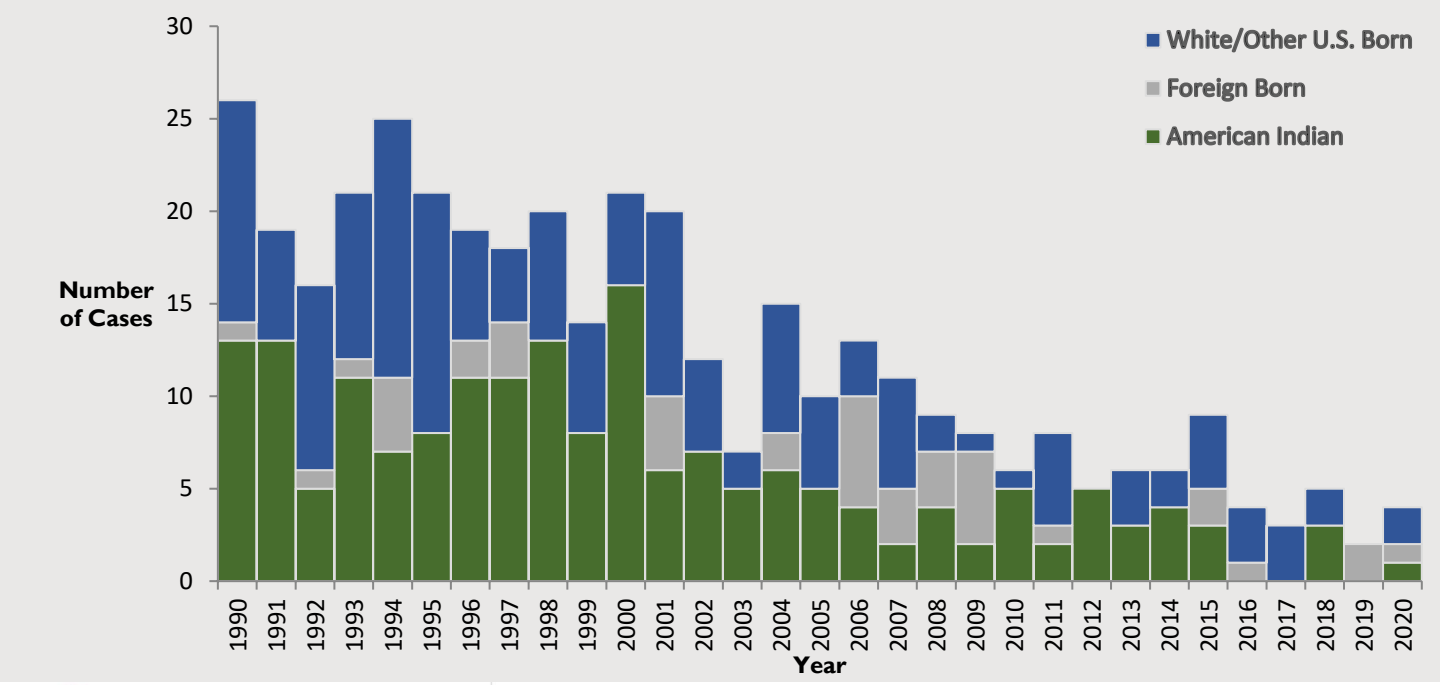
TB Surveillance Update (Table)

- Four patients with new, active tuberculosis were reported in Montana in 2020.
- Counties of residence for the TB cases included **Silver Bow, Yellowstone, Rosebud** and **Missoula**.
- One patient had pulmonary/pleural disease, one had lymphatic TB, one had ovarian TB, and the fourth had *M. bovis* of the peritoneum.
- CDC does not distinguish between *M. tuberculosis* and *M. bovis* as both are infectious and cause almost identical disease in humans.
- One of the patients had an Isoniazid drug-resistant TB organism.
- Patient risk factors included: birth or travel in TB endemic countries and immunosuppression (not HIV/AIDS).
- One patient was foreign born.
- All the cases were found incidentally and very early in disease. None of them had typical signs and symptoms of active TB disease.
- No contacts were found to be infected by the four cases.

TB Trends (Figures 1 and 2)

- Incidence rates of TB in Montana and the United States have been decreasing; the 2020 MT rate (0.4 cases per 100,000 population) was 5.5 times lower than the 2020 U.S. rate (2.2 cases per 100,000 population; 2020 U.S. rate may have been affected by the COVID-19 pandemic)
- During the past 10 years, an average of 5.2 cases per year, approximately 0.5 case per 100,000 population, were reported (range: 2 to 9 cases)
- During the most recent five-year period (2016–2020) an average of 3.6 cases per year, or ~0.3 cases per 100,000 population, were reported in Montana
- TB cases among American Indians have declined from an average of 10 cases per year in the 1990s to 5.7 cases per year in the 2000s to 2.5 cases per year in the 2010s.
- During the last 10 years (2011 – 2020) TB cases among American Indians has dropped to an average of 2.1 cases per year, and the last 5 years an average of 0.8 cases per year were reported in Montana.

FIGURE 1. REPORTED ACTIVE TUBERCULOSIS CASES BY RACE — MONTANA, 1990–2020



Data source: DPHHS Montana Infectious Disease Information System

FIGURE 2. TUBERCULOSIS INCIDENCE RATE — MONTANA AND UNITED STATES, 2005–2020

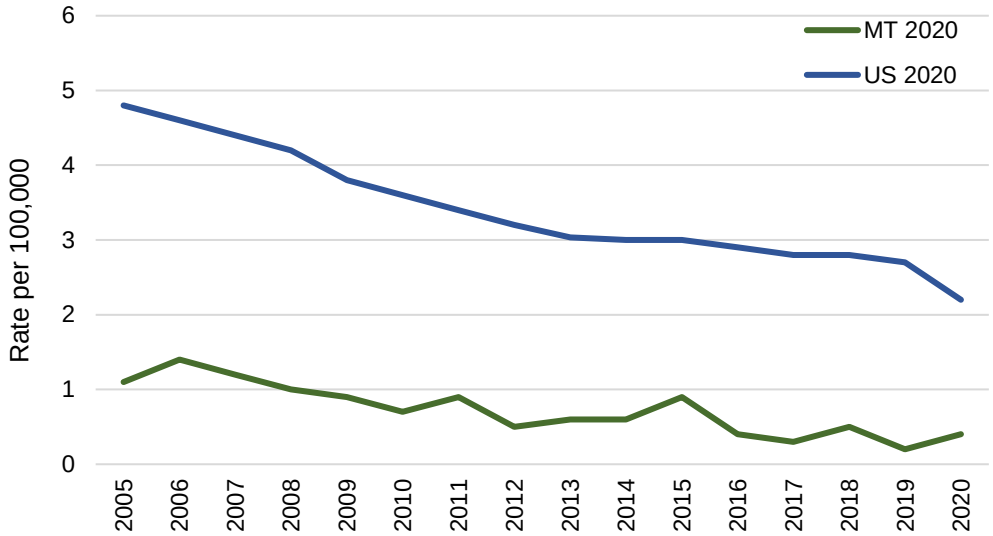


TABLE. TUBERCULOSIS CASE SUMMARY—MONTANA, 2018-2020

Characteristics	2018	2019	2020
New TB Cases	5	2	4
Incidence Rates (per 100,000)			
Montana	0.5	0.2	0.4
Sex			
Male	4	2	-
Female	1	-	4
Age at diagnosis (years)			
<5	-	-	-
5-14	-	-	-
15-24	1	-	-
25-44	1	1	1
45–64	2	1	1
≥65	1	-	2
Race, Ethnicity			
Non-Hispanic, White	2	1	2
Non-Hispanic, American Indian	3	-	1
Non-Hispanic, Other	-	-	1
Site of Disease			
Pulmonary/Pleural	4	1	1
Extrapulmonary only	1	1	3
Pulmonary & Extrapulmonary	-	-	-
Drug Resistance			
No resistance	5*	2	3
Isoniazid resistance	-	-	1
Multiple-drug resistance	-	-	-
Country of Origin			
U.S. born	5	-	3
Foreign born	-	2	1

*One or more patients met the definition of a clinical case but were culture-negative so susceptibility testing could not be completed

Data source: DPHHS Montana Infectious Disease Information System

Attachment F to Contract No.

ASSURANCE OF COMPLIANCE WITH CERTAIN REQUIREMENTS FOR SUBSTANCE USE DISORDERS TREATMENT SERVICE

On behalf of _____, in relation to the performance of services under the proposed contract, I certify to the Department the following:

Pregnant Women and Women with Dependent Children

1. The program treats the family as a unit and, therefore, admits both women and their Children into treatment services, if appropriate.

2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.

3. The program provides or arranges for child-care while the women are receiving services.

4. The program provides or arranges for primary pediatric care for the women's children, including immunizations.

5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.

6. The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

7. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) Through (6.) above.

Capacity of Treatment for Intravenous Drug Abuser:

If the program treats individuals for intravenous substance abuse, the program must adhere to items (8) through (15).

8. Within 7 days of reaching 90 percent of its treatment capacity, the program notifies the State that 90 percent of the capacity has been reached.

9. The program admits each individual who requests and is in need of treatment for intravenous drug abuse not later than:

    a. 14 days after making the request or

b. 120 days if the program has no capacity to admit the individual on the date of the request and, within 48 hours after the request, the program makes interim services available until the individual is admitted to a substance abuse treatment program.

10. When applicable, the program offers interim services that include, at a minimum, the following:

    a. Counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
    b. Provides an at-risk assessment and referral for HIV or TB treatment services, if necessary, and assures proper reporting of any active cases.
    c. Follow health care recommendations for treatment active individuals and protection of others from disease transmission.
    d. Counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women.

11. The program has established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.

12. The program has a mechanism that enables it to:

    a. Maintain contact with individuals awaiting admission
    b. Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area.

13. The program takes clients awaiting treatment for intravenous substance abuse off the waiting list only when one of the following conditions exists:

    a. Such persons cannot be located for admission into treatment or
    b. Such persons refuse treatment.

14. The program carries out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:

    a. The standard intervention model as described in *The NIDA Standard intervention Model for Injection Drug Users: Intervention Manual,* National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992).
    b. The health education model as described in Rhodes, F., Humfleet, G.L. Et al., *AIDS Intervention Program for Injection Drug Users: Intervention Manual*, (Feb. 1992).

c. The indigenous leader model as described in Wiebel, W., Levin, L.B., *The indigenous Leader Model: Intervention Manual*, (Feb. 1992).

15. The program ensures that outreach efforts (have procedures for):

a. Selecting, training, and supervising outreach workers.
b. Contacting, communicating, and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of Federal and State confidentiality requirements.
c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV.
d. Recommending steps that can be taken to ensure that HIV transmission does not occur.

Requirements Regarding Tuberculosis

16. The program directly, or through arrangements with other public or nonprofit private entities, routinely makes available the following TB services to each individual receiving treatment for substance abuse:

a. Counseling the individual with respect to TB
b. Screening to determine if an individual has been at risk of being infected with mycobacterium TB to determine the appropriate services for the individual.
c. Providing for or referring the individuals infected by mycobacterium TB appropriate medical evaluation and treatment and assure proper reporting of active clients.

17. For clients denied admission to the program on the basis of lack of capacity, the program refers such clients to other providers of TB services and facilitates access to those services.

18. The program has implemented the infection control procedures that are consistent with those established by the Department to prevent the transmission of TB and that address the following:

a. Screening patients and identification of those individuals who are at high risk of becoming infected.
b. Assure that all State reporting requirements are followed while adhering to Federal and State confidentiality requirements, including 42 CFR part 2.
c. Case management activities to ensure that individuals receive such services.

Treatment Services for Pregnant Women

19. The program gives preference in admission to pregnant women who seek or are referred for and would benefit from SABG SUD Block Grant funded treatment services. Further, the program gives preference to clients in the following order:

a. To pregnant injecting drug users first
b. To other pregnant substance abusers second
c. To other injecting drug users third
d. To all other individuals fourth

20. The program makes available interim service within 48 hours to pregnant women who cannot be admitted because of lack of capacity.

Special Term: Marijuana Restriction

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements.") 21 U.S.C. §§ 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Additional Requirements

21. The program makes continuing education in treatment services available to employees who provide the services.

22. The program has in effect a system to protect patient records from inappropriate disclosure, and the system:

a. Is in compliance with all applicable State & Federal laws and regulations, including 42 CFR part 2.
b. Includes provisions for employee education on the confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure.

23. The program does not expend SABG SUD Block Grant funds to provide inpatient hospital substance abuse services, except in cases when each of the following conditions are met:

a. The individual cannot be effectively treated in a community-based, non-hospital, residential program.

b. The daily rate of payment provided to the hospital for providing the services does not exceed the comparable daily rate provided by a community-based, non-hospital, residential treatment program.

24. The program does not expend SABG SUD Block Grant funds to purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.

25. The program does not expend SABG SUD Block Grant funds to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

26. The program does not expend SABG SUD Block Grant funds to provide financial assistance to any entity other than a public or nonprofit private entity.

27. The program does not expend SABG SUD Block Grant funds to make payments to intended recipients of health services.

28. The program does not expend SABG SUD Block Grant funds to provide individuals with hypodermic needles or syringes.

29. The program does not expend SABG SUD Block Grant funds to provide treatment services in penal or correctional institutions of the State.

30. The program uses the SABG SUD Block Grant as the “payment of last resort” for services for pregnant women and women with dependent children, TB services, and HIV services and, therefore, makes every reasonable effort to do the following:

    (a.) Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX, any State compensation program, and other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.
    (b.) Secure from patients or client’s payments for services in accordance with their ability to pay.

31. The Program may not use funds in this Task Order to pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Executive Level I of the Federal Executive Pay Scale or $186,600.00.

Strongly Encouraged Services for Women

32. The program provides pregnant women, women with dependent children, and their children, either directly or through linkages with community-based organizations, a comprehensive range of service to include:

    a. Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments
    b. Employment and training programs

c. Education and special education programs
d. Drug-free housing for women and their children
e. Prenatal care and other health care services
f. Therapeutic day care for children
g. Head Start
h. Other early childhood programs

Not all of these assurances may be pertinent to Tribal circumstances. This assurance form, however, is standardized for general use and signing it is intended to encompass only provisions applicable to the circumstances in relation to the federal monies that are being received.

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    b. Provides an at-risk assessment and referral for HIV or TB treatment services, if necessary, and assures proper reporting of any active cases.
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18. The program has implemented the infection control procedures that are consistent with those established by the Department to prevent the transmission of TB and that address the following:

a. Screening patients and identification of those individuals who are at high risk of becoming infected.
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    (a.) Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX, any State compensation program, and other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.
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    a. Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments
    b. Employment and training programs

c. Education and special education programs
d. Drug-free housing for women and their children
e. Prenatal care and other health care services
f. Therapeutic day care for children
g. Head Start
h. Other early childhood programs

Not all of these assurances may be pertinent to Tribal circumstances. This assurance form, however, is standardized for general use and signing it is intended to encompass only provisions applicable to the circumstances in relation to the federal monies that are being received.

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$4,230,462.00		$11,386,675.00	$1,788,694.00	$8,016,996.00	$3,658,030.00	$0.00		$0.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$1,000,000.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
b. All Other	$3,230,462.00		$11,386,675.00	$1,788,694.00	$8,016,996.00	$3,658,030.00	$0.00		$0.00	$0.00
2. Primary Prevention[d]	$2,576,411.00		$0.00	$3,421,000.00	$244,522.00	$0.00	$0.00		$0.00	$0.00
a. Substance Abuse Primary Prevention	$2,576,411.00		$0.00	$3,421,000.00	$244,522.00	$0.00	$0.00		$0.00	$0.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
5. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$348,423.00		$1,014,863.00	$121,251.00	$671,069.00	$0.00	$0.00		$0.00	$0.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$7,155,296.00**	**$0.00**	**$12,401,538.00**	**$5,330,945.00**	**$8,932,587.00**	**$3,658,030.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	126	60
2. Women with Dependent Children	1,583	741
3. Individuals with a co-occurring M/SUD	7,624	3,565
4. Persons who inject drugs	4,870	2,277
5. Persons experiencing homelessness	2,091	978

Please provide an explanation for any data cells for which the state does not have a data source.

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Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]	FFY 2023 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$4,230,462.00	$1,427,423.00	$633,366.00	$4,230,462.00	$1,427,423.00	$0.00
2 . Primary Substance Use Disorder Prevention	$2,576,411.00	$2,351,817.00		$2,576,411.00	$2,351,817.00	$0.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$348,423.00	$326,549.00	$282,019.00	$348,423.00	$326,549.00	$0.00
6. Total	**$7,155,296.00**	**$4,105,789.00**	**$915,385.00**	**$7,155,296.00**	**$4,105,789.00**	**$0.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B			B		
Strategy	IOM Target	FFY 2022			FFY 2023		
		SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]	SA Block Grant Award	COVID-19 Award[4]	ARP Award[5]
1. Information Dissemination	Universal	$440,575	$469,341	$0	$440,575	$469,341	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$440,575**	**$469,341**	**$0**	**$440,575**	**$469,341**	**$0**
2. Education	Universal	$110,618	$592,733	$0	$110,618	$592,733	$0
	Selected	$2,105	$1,765	$0	$2,105	$1,765	$0
	Indicated	$4,832	$4,051	$0	$4,832	$4,051	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$117,555**	**$598,549**	**$0**	**$117,555**	**$598,549**	**$0**
3. Alternatives	Universal	$180,544	$151,353	$0	$180,544	$151,353	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$20,018	$16,782	$0	$20,018	$16,782	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$200,562**	**$168,135**	**$0**	**$200,562**	**$168,135**	**$0**
4. Problem Identification and Referral	Universal	$14,565	$12,210	$0	$14,565	$12,210	$0
	Selected	$20,847	$17,476	$0	$20,847	$17,476	$0
	Indicated	$33,997	$28,500	$0	$33,997	$28,500	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$69,409**	**$58,186**	**$0**	**$69,409**	**$58,186**	**$0**
	Universal	$819,252	$759,254	$0	$819,252	$759,254	$0

5. Community-Based Processes	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$819,252**	**$759,254**	**$0**	**$819,252**	**$759,254**	**$0**
6. Environmental	Universal	$93,465	$78,353	$0	$93,465	$78,353	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$93,465**	**$78,353**	**$0**	**$93,465**	**$78,353**	**$0**
7. Section 1926 Tobacco	Universal	$236,266	$0	$0	$236,266	$0	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$236,266**	**$0**	**$0**	**$236,266**	**$0**	**$0**
8. Other	Universal	$0	$0	$0	$0	$0	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$1,977,084**	**$2,131,818**	**$0**	**$1,977,084**	**$2,131,818**	
Total SABG Award[3]		**$7,155,296**	**$4,105,789**	**$915,385**	**$7,155,296**	**$4,105,789**	
Planned Primary Prevention Percentage		**27.63 %**	**51.92 %**	**0.00 %**	**27.63 %**	**51.92 %**	

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

[4]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

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Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	FFY 2022 COVID 19 Award[1]	FFY 2022 ARP Award[2]	FFY 2023 SA Block Grant Award	FFY 2023 COVID 19 Award[3]	FFY 2023 ARP Award[4]
Universal Direct	$350,873	$794,142	$0	$350,873	$794,142	$0
Universal Indirect	$1,544,418	$1,269,102	$0	$1,544,418	$1,269,102	$0
Selected	$22,952	$19,241	$0	$22,952	$19,241	$0
Indicated	$58,847	$49,332	$0	$58,847	$49,332	$0
Column Total	**$1,977,090**	**$2,131,817**	**$0**	**$1,977,090**	**$2,131,817**	
Total SABG Award[5]	**$7,155,296**	**$4,105,789**	**$915,385**	**$7,155,296**	**$4,105,789**	
Planned Primary Prevention Percentage	**27.63 %**	**51.92 %**	**0.00 %**	**27.63 %**	**51.92 %**	

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[4]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Bath salts, Spice, K2)	☐	☐	☐
Targeted Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☐	☐	☐
Hispanic	☐	☐	☐
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Table 6 Non-Direct Services/System Development

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	FFY 2022					FFY 2023				
Activity	**A. SABG Treatment**	**B. SABG Prevention**	**C. SABG Integrated[1]**	**D. COVID -19[2]**	**E. ARP[3]**	**A. SABG Treatment**	**B. SABG Prevention**	**C. SABG Integrated[1]**	**D. COVID -19[2]**	**E. ARP[3]**
1. Information Systems	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
2. Infrastructure Support	$10,000.00	$0.00	$0.00	$0.00	$0.00	$10,000.00	$0.00	$0.00	$0.00	
3. Partnerships, community outreach, and needs assessment	$10,000.00	$0.00	$0.00	$0.00	$0.00	$10,000.00	$0.00	$0.00	$0.00	
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
5. Quality Assurance and Improvement	$100,000.00	$0.00	$0.00	$0.00	$0.00	$100,000.00	$0.00	$0.00	$0.00	
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
7. Training and Education	$0.00	$599,322.00	$0.00	$220,000.00	$0.00	$0.00	$599,322.00	$0.00	$220,000.00	
8. Total	**$120,000.00**	**$599,322.00**	**$0.00**	**$220,000.00**	**$0.00**	**$120,000.00**	**$599,322.00**	**$0.00**	**$220,000.00**	**$0.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

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[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

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[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

The Department of Public Health and Human Services (DPHHS) Addictive and Mental Disorder Division (AMDD) oversees all behavioral health funded by Medicaid and other federal or state funds. AMDD develops administrative rules and provider manuals that specify provider requirements for Medicaid or other federal/state reimbursement. AMDD also manages the State Plan Amendments (SPA) for all behavioral health services approved by CMS. Through the administrative rules, provider manuals, and SPA, integration of behavioral health and primary care is prioritized in all settings, whether an individual enters through the primary health or behavioral health door.

Specifically, the Health Resources Division (HRD) oversees all provider requirements and reimbursement for primary care providers, Federally Qualified Health Centers (FQHC), Rural Health Clinics, Tribal Health Clinics, Urban Indian Health Centers, and Hospitals/Critical Access Hospitals in MT. AMDD works closely with HRD to make sure the behavioral health service requirements align under Medicaid. Additionally, HRD initiated the Patient Centered Medicaid Home (PCMH) in 2014 as a reimbursable service under MT Medicaid. PCMH is a team of healthcare professionals who transformed their focus from just treating illness after the fact to keeping individuals healthy and avoiding expensive complications. A PCMH utilizes a “team” of people in various positions, such as physicians, physician assistants, nurse practitioners, nurses, care coordinators, dieticians, behavioral health consultants, and pharmacists to coordinate all aspects of individuals’ health. The care team engages individuals as an active participant in their healthcare through better communication regarding the individual’s responsibility for their own health. PCMHs provide a comprehensive approach to healthcare, addressing every aspect of individuals’ health, at all stages of life. PCMHs coordinate care with other parts of the healthcare system such as specialty healthcare providers, hospitals, and nursing homes. Some PCMHs also connect individuals to community resources such as affordable housing or affordable health insurance. PCMHs prevent and manage disease better by following up with individuals to ensure that preventive care and necessary treatment for chronic disease is delivered in a timely and appropriate manner. HRD also initiated Comprehensive Primary Care Plus (CPC+) in January 2017. At this time, MT became 1 of the 14 national locations to introduce the CPC+ model, which at the time was a new, innovative, value-based five-year payment and delivery reform model. CPC+ gives practices the flexibility to deliver primary health care in more innovative ways, in the manner that best meets individuals’ needs, without being tethered to the 20-minute office visit. It allows practices to pool this “non-visit-based funding” from multiple public and private payers and apply it to a whole-population proactive primary care management strategy.

Additionally, there are new partnerships developing between specialty behavioral health providers (licensed mental heath centers and state approved substance use treatment providers) who are establishing a memorandum of agreement with the local FQHC to provide access to primary care and other medical services such as Medication for Opioid Use Disorder (MOUD).

Lastly, there is current collaborations using telehealth services for integrating behavioral health into hospital settings. Through the MOUD project, hospitals are collaborating with psychiatrists, waivered MOUD providers and behavioral health clinicians to provide access to telehealth services to patients who are admitted to the hospital or emergency department. Through memorandum of agreements, these providers ensure access to follow-up services once the patient is discharged from the hospital or ED.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

AMDD oversees and implements the provider requirements and funding for adult and youth substance use disorder treatment and adults with serious mental illness. The Childrens Mental Health Bureau oversees and implements provider requirements and funding for youth mental health services for children 0-18.

Licensed Mental Health Centers (MHC) and State Approved SUD Treatment programs are eligible for Medicaid and other federal and state funds for behavioral health services. Many Licensed MHC and State Approved programs integrated co-occurring services into their continuum or will contract with a local provider to ensure access to co-occurring services. Many of these programs also provide treatment to youth and adolescents with co-occurring needs.
AMDD also administers MCDC, the only State administered medically monitored and high intensive residential SUD treatment facility. Significant to the evolution of treatment at MCDC is the recognition and implementation of integrated treatment for individuals with co-occurring disorders. Medication for Opioid Use Disorder (MOUD) is being implemented as an evidence-based intervention. MCDC utilizes an interdisciplinary team consisting of physicians, nurses, mental health therapists, addictions counselors, and treatment aides and peer support specialists.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ◉ No

b) and Medicaid? ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The State can track the number of individuals who accessed M/SUD services, but there is no State mandate to monitor access to mental health/SUD services by Medicaid. Additionally, Montana Medicaid is Fee-for-Service and not a Managed Care system (Qualified Health Plan).

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes ◉ Yes ○ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ◉ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ◉ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

With the passage and reauthorization of Medicaid Expansion, along with approved CMS Waivers, MT is afforded a comprehensive service array that covers most of the behavioral health continuum of care. The biggest challenge is access to behavioral health workforce in the rural and frontier communities across the state. Telehealth has bridged some of the gap but the workforce shortage significantly impacts access to behavioral health services.

10. Does the state have any activities related to this section that you would like to highlight?

Montana 2019 legislature reauthorized Medicaid Expansion.
Currently submitting an 1115 Waiver to CMS.
Continued work expanding access to Certified Behavioral Health Peer Support Specialists.
Extensive and comprehensive training and technical assistance on integrated behavioral health in collaboration with many state partners.

Please indicate areas of technical assistance needed related to this section

None at this time

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

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[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	( ) Yes (•) No
e) Gender identity	( ) Yes (•) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (•) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ( ) Yes (•) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (•) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? (•) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight?

None at this time

Please indicate areas of technical assistance needed related to this section

None at this time

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

None at this time

Please indicate areas of technical assistance needed related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

In February 2020, all Program Managers, Project Directors, Bureau Chiefs and Fiscal staff attended a two-day training on Federal grant compliance and contract monitoring. This training resulted in improved processes and guidelines/procedures for monitoring all subcontractors on both programmatic and fiscal requirements.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

In the past 18 months (since Feb. 2020) there have been 4 Tribal Consultations with DPHHS Medicaid.

2. What specific concerns were raised during the consultation session(s) noted above?

August 26, 2021 - focus on Governor's HEART Initiative (for behavioral health priorities)
August 24, 2021 - focus on WASP (Medicaid program)
May 18-19, 2021 - focus on 2021 Legislative outcomes, ARPA and 1115 Waiver
August 25-26, 2020 - COVID, Telehealth, Certified Peer Support
February 20, 2020 - SDMI

3. Does the state have any activities related to this section that you would like to highlight?

All 8 tribal councils are actively engaged in identifying behavioral health needs and strategies for American Indians in MT through DPHHS tribal consultations.

Please indicate areas of technical assistance needed related to this section.

None at this time.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

The MT PNA Survey (Prevention Needs Assessment 2020) - attached

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☑ Rural communities
- ☐ Others (please list)

See SEOW (One-Pagers for 2020/2021).

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)

Birth/Death Records
• Crime data through the Board of Crime Control
• Liquor and Tobacco Licenses
• Hospital Data
• Medicaid Data
• Vehicle Crashes/Fatalities through Department of Corrections
• Licensed/State Approved Mental Health and Substance Use Disorder Treatment Facilities
Mortality and morbidity data also available by state and county level.

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [x] Monitoring the Future
- [x] Communities that Care
- [ ] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

SABG – Block Grant Funding is broken into the 5 Health Planning Regions. This round of Block Grant funding was structured to mirror the Montana Health Planning Regions. Additionally, the Department recognized a need for more Technical Assistance oversight to community Prevention Specialists. To accomplish this, the Department contracted with Youth Connections, a prevention agency in Helena, to employ 5 Regional Technical Assistance Leaders-one for each health planning region. Additionally, one community-based provider was selected to be the hub for prevention in each region.

Northwest Region
A maximum number of Prevention Specialists assigned to each community are as follows: Flathead: (1.0), Lincoln: (.5), Mineral: (.5), Missoula: (1.0), Ravalli: (1.0), Sanders (.5)
Total: 4.50 FTE, 9,360 Allocated Units of Service

Southwest Region
A maximum number of Prevention Specialists assigned to each community are as follows: Beaverhead: (.5), Butte-Silver Bow: (.75), Deer Lodge: (.5), Gallatin: (1.0); Jefferson: (.5), Lewis & Clark: (1.0), Madison: (.5), Park: (.50), Powell: (.5)
Total: 5.75 FTE, 11,960 Allocated Units of Service

North Central Region
A maximum number of Prevention Specialists assigned to each community are as follows: Cascade: (1.0), Pondera: (.5), Toole: (.5)
Total: 2.0 FTE, 4,160 Allocated Units of Service

South Central Region
A maximum number of Prevention Specialists assigned to each community are as follows: Carbon: (.5), Fergus: (1.0), Stillwater: (.5), Yellowstone: (1.0),
Total: 3.0 FTE, 6,240 Allocated Units of Service

Eastern Region
A maximum number of Prevention Specialists assigned to each community are as follows: Custer: (.5), Dawson: (1.0), Fallon: (.5), Phillips: (.5), Richland: (1.0), Valley: (.75),
Total: 4.25 FTE, 8,840 Allocated Units of Service

Reservations
Each Reservation is funded at .75 FTE.
Total: 5.25 FTE, 10,920 Allocated Units of Service

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

While the state does not currently have a licensing or credentialing process for prevention workforce, the DPHHS, AMDD are working with the Montana Healthcare Foundation, and the University of Montana to implement Prevention Specialist Certification in Montana. Fiscal Year 2022 will be the first year for grandfathering process.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

Regional TA Summary:
The State Block Regional Technical Assistance RFP was awarded to Youth Connections Coalition. YC is a non-profit based in Helena, MT
The State created 5 Regions based on the current State Health Planning Regions.
Each of the 5 Regions in the State of Montana will have 1 FTE Regional Technical Assistance Leader (RTAL) to provide the below mentioned assistance to 25 counties and 7 reservations: “Oversight, training and technical assistance to community-based prevention specialists in the areas of program development, quality assurance and data tracking, prevention workforce development and cultural competence training, and program evaluation.”

“Technical Assistance (TA) provided will include training and support in aligning community-based prevention strategies to priorities outlined in the public health Community Health Assessments and other community-based needs assessments regarding substance misuse/abuse; enhance existing coalition cohesiveness within the community to identify and implement evidence-based strategies, policies and programs to address the prevention outcomes and indicators outlined under the Block Grant State RFP and in the county-level public health Community Health Assessment; training on media development, quality assurance and other areas as approved by the Department.
The Program goals and objectives for the Regional Technical Assistance Prevention award are (4):

1. Maximize and target training and technical assistance resources by coordinating efforts across multiple sectors to recruit, retain, educate and train the prevention workforce;
2. Increase the use of evidence-based programs and strategies that lead to measurable outcomes;
3. Increase the reach of prevention training through the application and use of technology (online classes, self-paced courses and webinars); and
4. To assist the community-based prevention awarded contractors in meeting Prevention Outcomes and Indicators and Program and Reporting requirements.

Regional Technical Assistance Leaders will be required to engage in the following technical assistance activities to provide expertise on program development tasks.
a. Become a certified coach for Communities that Care Model, one per region;
b. Ensure community prevention specialists are engaged, coordinating and collaborating with the public health Community Health; and
c. Assessment (CHA) and Community Health Improvement Plan (CHIP) to address substance use/misuse prevention needs.

Assist community prevention specialists with:
a. Developing prevention plans using a department provided logic model approach. Prevention plans must be pre-approved by the RTAL and Department to ensure the community-based strategies and activities utilize science-based principles and align with the State Health Improvement Plan (SHIP);
b. State Health Improvement Plan (SHIP);
c. Completing the media campaign notification and assist in compliance to the Social Media Policy requirements;
d. Developing community prevention budgets; and
e. Integrate community prevention efforts by using both the Strategic Prevention Framework and Public Health Model to ensure collaboration.

The goal is to have one functional prevention plan for a community that encompasses existing needs assessments;
a. Building strong relationships with community leaders;
b. Identifying evidence-based programs and strategies that best align to address the community needs as well as align with available resources, working in collaboration with Department's Evidence-Based Workgroup;
c. Assist prior to submission of required data to the Department, to ensure information is complete and accurate; and
d. Completing an annual community coalition evaluation and coalition member retention rates. RTAL will provide TA on implementing the annual evaluation, will review the collected data to ensure fidelity and response rate are met before submitting to the Department.

Quality Assurance/Data Tracking System (required):
a. Assist with fiscal monitoring and provide TA on best-fit prevention activities to spend down funds;
b. Review monthly FEi WITS data entries for compliance with federal and Department reporting standards;
c. Participate with the Department on Community-based Prevention Contractor's annual performance review; and
d. Review monthly submission of community prevention specialist workforce development training in FEI systems WITS. Monitor monthly hours and report any discrepancies to the community prevention specialist.

Workforce training and TA (required)
a. Identify training needs by conducting needs assessment within first 120 days;
b. Develop a workforce training 5 year plan;
c. Coordinate and provide SAPST (32 hours), Logic Model web-based training, WITS training (Substance Abuse Prevention Skills Training);
d. Provide and develop an annual training schedule to be approved by the Department;
e. Provide information on available training opportunities;
f. Participate in Quarterly Prevention Skype meeting;
g. Provide technical assistance in a variety of formats; and
h. Explore with the Department a credentialing process for prevention workforce.

Program Evaluation (required):
a. Develop and implement an evaluation of training and TA services and submit a summary of progress to the Department annually; and
b. Review prevention plan/logic models for each community prevention specialist to monitor the progress of measures. Work with Department and PS to revise prevention plans if measures are not being met.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

Communities develop a community prevention plan / logic model, an interactive process for identifying the readiness of communities to implement identified and needed strategies. The process by which readiness is identified include the following processes:
1. Through the Communities the Care (CTC) model, which is being implemented in 13 communities across Montana, coalitions use the processes outlined to determine readiness;
2. Through the County Health Assessment process, communities are guided through a collective impact model to identify community needs and develop a community health improvement plan; all 56 counties in MT have conducted a Community Health Assessment and all have identified Substance abuse / misuse to be a priority health concern.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

See Substance Abuse Strategic (SUD) Strategic Plan and State Health Improvement Plan (SHIP), and Prevention Logic Model.
See Attachments:
BG Logic Model - 2019-2025
Montana Substance Use Disorder Task Force - Strategic Plan- 2020-2023
(Montana State Health Improvement Plan (SHIP) - 2019-2023

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☑ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? (●) Yes ( ) No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

See Attachments:
Guide to Evidence Based Workgroup

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Health fairs
Billboards
Media Advocacy
Media Campaigns
Newspaper Stories
Radio and Television Public Service Announcements
Resource Directories
Social Norms Media Campaign
Speaking Engagements/ Community Presentations
Sticker Shock Campaign
Town Hall Meetings
NOTE: Dissemination of Information – Statewide Campaign
Parenting Montana Campaign:
Provides easy to use parenting tools that grow social and emotional skills in children – skills that lead to healthy and successful lives and reductions in risky behaviors like underage drinking. The tools are appropriate for elementary, middle, and high school children.

The ParentingMontana.org Prevention Specialist's Guide is designed to help Prevention Specialists engage parents in their communities to use the ParentingMontana.org website and tools. Included are guidance and resources to work with schools, social service agencies, healthcare providers, law enforcement, and others to connect parents and those in a parenting role to the ParentingMontana.org website. Online training resources are also available to support Montana's prevention workforce.

Prevention Specialists can login on the bottom to access information on media, resources, coalition education and support and access to resources. To access this guide, go to:
LINK: https://parentingmontana.org

b) Education:

PAX Good Behavior Game
PAX Tools Training
Positive Action
ACEs
Youth Leadership Development
Distracted Drivers Training
SAPST
Creating Lasting Family Connections
SMART Moves
Life Skills
Classroom and Small Group Sessions
Cultural Program
Education Programs for Youth Groups
Groups for Children of Substance Abusers
Parenting and Family Management Classes
Peer Leader and Peer Helper Programs

c) Alternatives:

Community Drop In Centers
Community Service Activities
Drug-Free Dances and Parties
Drug-Free Social and Recreational Activities
Mentoring Programs
Youth and Adult Leadership Activities

d) Problem Identification and Referral:

Driving While Intoxicated Education Programs (DIRECT)
Employee Assistance Programs
On-line screening e-checkup (e-CHUG)
Student Assistance Programs
Teen Courts

e) Community-Based Processes:

Tribal Action Plans
Community Coalitions
Accessing Services and Funding
Communities that Care PLUS
Community and Volunteer Training
Community Mobilization
DUI Task Force
Local Advisory Councils
Systematic Planning
Technical Assistance to Coalition Members

f) Environmental:

Retail Alcohol Sales and Service Training

Take Back Events
Reward and Reminder for both Tobacco and Alcohol
Drop boxes
Deterra bag distribution to pharmacies
ATOD Compliance Checks
ATOD-Free School Policies
ATOD Policy Advocacy, Enactment, or Implementation
ATOD Product Pricing Strategies
Beverage Server Training or RASS training
Court Monitoring
Happy Hour Restrictions
Increased ATOD Taxes
Keg Registration
Neighborhood Surveillance/Watches
Party Patrols
Policies to Reduce ATOD Outlet Density
Restricting Alcohol Sales at Public Events
Retailer Recognition- Reward & Reminder
Review and Modification of ATOD Advertising Practices
Shoulder Tap Programs
Social Host Laws
Tip Line

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

All activities are under contract and must be approved by the Department prior to implementation and monitored through the WITS data system.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

We have completed a Final Evaluation Plan - September 2021 - attached

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☑ Binge use
- ☑ Perception of harm

c) ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Partnership for Success Grant and Substance Abuse Prevention and Treatment Block Grant Evaluation Plan 2018-2023

PFS

Grant Award Number: 1H79SP080974-01

Grantee Name: Lonni Starcevich

Grantee Address: 100 North Park Avenue – Suite 300, Helena, MT 59620-2905

Project Officer Name: Damaris Richardson

Prepared by:

Courtney Geary, Program Evaluator

Will Gardner, Epidemiologist

Laura Williamson, State Epidemiologist

Lonni Starcevich, Prevention Program Manager

Gina Tracy, Substance Abuse Block Grant Manager

Kimber Koch, Prevention Section Supervisor

Report updated September 8, 2021

INTRODUCTION

Purpose

The purpose of this evaluation is to monitor the Partnership for Success and Substance Abuse Prevention and Treatment Block grant over a five-year period (2018-2023). The evaluation will answer the following questions:

1. To what extent did the Partnership For Success and Block Grant projects achieve the intended outcomes?
2. Were activities implemented as planned?
3. Did the program's services, products, and resources reach their intended audiences and users?

The findings will be used to compare to past evaluations, specifically, past concerns of overall Prevention Specialist Training and Technical Assistance available to them, increase community readiness, increase available data resources, and a continued decrease in National Outcome Measures (NOMs). The findings will also be used to assess if goals were met for the overall grant period and discuss how to move forward with future grant periods.

Stakeholder Involvement

Stakeholder	Contribution to Evaluation Planning	Interest
Substance Abuse and Mental Health Services Administration (SAMHSA)	SAMHSA requires certain aspects of the grants be analyzed and evaluated. These are integrated into the evaluation plan.	As the grant funder, SAMHSA holds an interest in seeing results from that funding.
Addictive and Mental Disorders Division (AMDD)	AMDD plays a key role in contribution to the finalization of the evaluation plan with the Partnership for Success Grant Manager, Lonni Starcevich, and Substance Abuse Prevention Grant Manager Gina Tracy, and the Prevention Section Supervisor, Kimberly Koch.	AMDD has a lead role in managing the grants and implementation of grant activities at the county or tribal level, the interest in the evaluation plan will active and supportive.
The Public Health and Safety Division (PHSD)	The Program Evaluator, Courtney Geary, the Epidemiologist, Will Gardner, SEOW Lead Analyst, Lauren White, and State Epidemiologist Laura Williamson, participate in evaluation plan creation and data collection. All three will collect and analyze certain data needed for the process and outcome evaluations.	Duties require active engagement in data collection and analysis, along with support to those in the prevention field.

Youth Connections/Regional Technical Assistance Leaders (RTALs)	RTALs provide training and technical assistance to Prevention Specialists and help with communication between PHSD/AMDD and the Prevention Specialists. They can provide insight into focusing the evaluation plan needs.	Interested in progress data over the grant period.
Boys & Girls Club	Will provide SMART Moves data (qualitative and quantitative). (PFS)	Will want to know if objectives required by grant proposal have been met.
Healthy Mothers and Healthy Babies	Will provide narrative data regarding progress. (PFS)	Will want to know of objectives required by grant proposal have been met.
CONNECT referral system	Objective provided through grant requirements. (PFS)	Will want to know of objectives required by grant proposal have been met.
Prevention Specialists	Prevention Specialists provide data through WITS and other surveys to help determine if goals are being met.	Will want to know if input from activities entered into WITS (CSAP, Evidence-Based Programs, those reached and served), quarterly reports, and coalition information are being received and utilized. Will also want to know if they are progressing towards grant goals.
Youth and Adults Served	The main target population for the programs who can provide critical perspective. Will provide data on if programs are reaching their intended audience.	Will want to be aware if programs being implemented in their community and are involved in are progressing towards community goals.
Communities That Care	Works in tandem with both grants to address adolescent health and behavior problems.	CTC uses processes for prioritizing risk and protective factors and setting specific, measurable community goals. The program will want to be aware of the success or limitations of certain programs in its community and may be able to provide input with some of its own data.

Background and Context of Partnership for Success and SABG

The Partnership for Success in Montana Project (PFS) will address one of the Substance Abuse and Mental Health Services Administration's (SAMHSA) priorities, the prevention of underage drinking among people aged 9 to 20, and two additional state priority substances: youth misuse of marijuana and methamphetamine. The Substance Abuse Block Grant (SABG) also aims for youth misuse of marijuana and underage drinking while also including adult binge drinking. The project uses the Strategic Prevention Framework to employ a two-level prevention approach. Level 1 focuses on 12 specific high-need counties by utilizing the Selective approaches. Level 2 utilizes Universal prevention approaches for disproportionately impacted populations in all counties. The 12 identified high-need counties to be served through Level 1 Selective approaches include: Big Horn, Blaine, Dawson, Deer Lodge, Hill, Glacier, Lake, Lincoln, Madison, Powell, Roosevelt, and Rosebud. Counties were selected by ranking prevalence of substance use and violations, probation rates, teen birth rates, juvenile offenses, and high-risk indicators (10+) for youth. These counties also have a high proportion of Native American residents, and experience high rates of unemployment, and poverty.

Context: The Partnership for Success is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by the Addictive and Mental Disorders Division (AMDD). Partnership for Success aims to address alcohol, marijuana, and methamphetamine use among youth and disproportionate populations (those on probation, in foster care, and on the reservation) in Montana. The Substance Abuse Prevention and Treatment Block Grant (SABGs), also funded by SAMHSA, is similar in its' goals, as it aims to reduce the 30-day use rates of underage drinking, marijuana use, and adult binge drinking. The SABG is awarded annually on the federal fiscal year, while Partnership for Success is a five-year grant, starting 2018. Both grants strive to achieve these goals by using evidence-based prevention strategies that align with Montana State Health Improvement outcomes and indicators.

Target population and Cultural Competence

The target population include Montana youth between the ages of 9 and 20 years for youth data and adults (18+) in general for the adult binge drinking, with an emphasis on at-risk youth populations including youth on probation, in foster care, and living on reservations. The Strategic Prevention Framework by SAMHSA incorporates cultural competency to address behavioral health disparities. Cultural competency incorporates respectful health beliefs, practices, and needs appropriately to the community, and is an important factor in order to work with, various populations disproportionately affected by substance abuse. In Montana, these particular populations include military veterans, American Indians, and LGBT individuals. While there are data gaps for these populations, attempts will be made to identify other available data sources.

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Program Goals, Outputs, and Outcomes

The Partnership for Success and Block Grant's goals are:

1. By September 2023, prevent the onset and reduce the prevalence of alcohol, marijuana, and methamphetamine in youth ages 9-20 and binge drinking in adults in funded counties, and among disproportionate populations (on probation, in foster care, and on reservations).

2. By September 2023, decrease in the number of youths at high-risk (having 10 or more risk factors) for substance use.

3. By September 2023, strengthen prevention capacity /infrastructure at the state, tribal and county levels.

4. By September 2023, strengthen the comprehensive prevention approach.

Outputs

1. By September 2023, increase the number of county partners utilizing CONNECT Montana online referral system and increasing the number of client referrals to services through the system in each funded county by 25% as measured in the Connect Referral System Provider Database. Baseline from Glacier County with 9/15 service Provider/Referral in 2016.
2. By September 2023, increase the number and percentage of evidence-based programs, policies or practices which target disproportionate populations in each of the funded counties by 15% as measured in WITs database reporting system.
3. By September 2023, all evidence-based programs funded through the grants will consist of 70% defined as effective, 20% defined as promising, and 10% defined as innovative by the state Evidence-Based workgroup.
4. By September 2023, increase the number of members to the Healthy Pregnancy Outcomes Consortium and the number of health service providers reached by Substance Abuse media materials for women of childbearing age from 4 to between 10 and 15.
5. By September 2023, 1200 youth (500 of which are involved in Foster Care/Grandparent Kinship Placement) within the ages of 9-18 will complete the SMART Moves (Skills Mastery and Resilience Training) substance use prevention education program implemented by the Montana Alliance of Boys & Girls Club.
6. By September 2023, the State Epidemiological Outcomes Workgroup meets quarterly to review the data needs of Montana communities, conduct research, and provide data and resources when needed.
7. By September 2023, the Evidence-based Workgroup meets quarterly to assess and update the standards for Montana's evidence-based program list, review programs to add to the list, and provide insights on the programs that should be used by Prevention Specialists.

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Outcomes

Partnership for Success Grant

1. By September 2023, reduce 30-day use of alcohol by youth by 5% in each funded county and statewide disproportionate populations as measured by the Prevention Needs Assessment (2016 PNA).
2. By September 2023, reduce 30-day use of marijuana by youth by 5% in each funded county and statewide disproportionate populations as measured by the Prevention Needs Assessment (2016 PNA).
3. By September 2023, reduce 30-day methamphetamine use by youth by 0.2% in each funded county and statewide disproportionate populations as measured by the Prevention Needs Assessment (2016 PNA).
4. By September 2023, decrease the number of youths at high risk (having 10 or more risk factors) for substance use by 5% in each funded county and statewide disproportionate populations as measured in the Prevention Needs Assessment (2016 PNA).

Block Grant

1. By September 2024, reduce 30-day alcohol use among youth in grades 9 through 12 combined from 33.1% to 26.1% (Baseline 2017 Montana YRBS).
2. 2. By September 2024, reduce 30-day marijuana use among youth in grades 9 through 12 combined from 19.8% to 12.8% (Baseline 2017 Montana YRBS).
3. By September 2024, reduce 30-day binge drinking among adults ages 21-65 from 18.9% to 11.9% (Baseline 2016 Montana BRFSS).

Report updated September 8, 2021

DATA COLLECTION AND ANALYSIS

Collection Methods and Analysis

Evaluation Question	Indicator	Standards	Data Source(s)	Data collection method
To what extent did the Partnership For Success and Block Grant projects achieve the intended outcomes?	% of youth who report 30-day use of alcohol.	At least 5% reduction for PFS. From 33.1% to 26.1% for Block Grant.	Montana PNA, YRBS, BRFSS	PNA, YRBS, and BRFSS data will all be collected and analyzed.
	30-day use of marijuana by youth.	At least 5% reduction for PFS. From 19.8% to 12.8% for Block Grant.		
	30-day methamphetamine use by youth.	At least 0.2% for PFS.		
	number of youths at high risk for substance use.	At least 5% reduction for PFS.		
	30-day binge drinking among adults ages 21-65.	From 18.9% to 11.9% for Block Grant.		
Were activities implemented as planned?	The 6 CSAP strategies are implemented in each county.	All 6 CSAP strategies are implemented (20% Information Dissemination, 20% Prevention Education, Alternatives, 10% Problem ID and Referral, 30% Community Based Processes, 10% Environment).	WITS, Biannual/annual assessment	The data collection method is self-report from Prevention Specialists, supervisors, RTALs, and grant managers via WITS or Biannual/annual assessment.
	# of target audiencereached for each program implmented.	At least % of target audience is reached.		
	% of each type of program being implemented (effective, promising, innovative)	Of the CSAP strategies, at least 70% are effective, 20% promising, and 10% innovative		
Did the program's services, products, and resources reach their intended audiences and users?	Number of Connect Referral	25% increase in CONNECT referrals	Annual/biannual assessments, ParentingMontana supplies survey, quarterly reports, WITS, CONNECT, Boys and Girls Club, and Healthy Mothers, Healthy Babies.	All assessments and quarterly reports will be collected and analyzed by the Evaluator.
	Number of Boys and Girls Club youth participating in SMART education program	Target 1200 youth with a reach of 500 youth involved in Foster Care/Grandparent Kinship Placement		
	Number of Healthy Mothers Healthy Babies Consortium members	Increase Consortium members from 4 to ?		

Report updated September 8, 2021

Both process evaluation and outcome evaluation are employed to understand the implementation of activities and the impact of the Partnership for Success grant and Block grant on substance use and misuse among youths 9-20 and binge drinking for adults. Through process evaluation, both qualitative and quantitative data will be used to compare to baseline data and assess project progress at both the local and state levels. Information for the process evaluation includes, but is not limited to, descriptions of local prevention activities, lessons learned, barriers encountered, and solutions developed as a result. Qualitative data for the outcome analysis result from assessments with the Prevention Specialists, RTALS, and supervisors and review of project materials. The qualitative data is analyzed to provide a description of changes in program policies and practices over time.

The purpose of the outcome evaluation is to assess changes in key prevention outcomes that occur as a result of various interventions. Outcomes will be investigated primarily at the state and local levels and compared over time within and across sites. Both qualitative and quantitative data are used to address these outcome questions. Data analyses include initial descriptive analysis of social and demographic characteristics, using univariate measures of central tendency (such as means, modes, and medians) and frequency distributions of the key outcomes of interest. FEI's Web Infrastructure for Treatment Services (WITS), the Montana Youth Risk Behavior Survey (YRBS), the Behavioral Risk Factor Surveillance System (BRFSS), and the Prevention Needs Assessment survey (PNA) will be the main data sources used in the outcome evaluation throughout the course of the overall evaluation.

Report updated September 8, 2021

Data Timeline

Activities	FFY1 (2018-2019)	FFY2 (2019-2020)	FFY3 (2020-2021)	FFY4 (2021-2022)	FFY5 (2022-2023)
Quarter 1 (Oct -Dec)	Prevention Specialists, Epidemiologist, and Evaluator being hired. No data collected.	• All FFY1 data is collected and reported for SPARS reporting • Data collected from WITS • Quarterly reports • RTAL Survey • WFD Survey • WITS reporting for previous FFY	• All FFY2 data is collected and reported for SPARS • Quarterly reports • Data collected from WITS • RTAL Survey • WFD Survey • WITS reporting for previous FFY	• All FFY3 data is collected and reported for SPARS • Quarterly reports • Data collected from WITS • RTAL Survey • WFD Survey • WITS reporting for previous FFY	• All FFY4 data is collected and reported for SPARS • Quarterly reports • Data collected from WITS • RTAL Survey • WFD Survey • WITS reporting for previous FFY
Quarter 2 (Jan – March)	• Quarterly reports • WITS data is beginning to be entered by Prevention Specialists • 2018 PNA data available	• Quarterly reports	• Quarterly reports • 2020 PNA data available	• Quarterly reports	• Quarterly reports • 2022 PNA data
Quarter 3 (April – June)	• Quarterly reports	• Quarterly reports • Data collected from WITS	• Quarterly reports • Data collected from WITS • CONNECT Survey	• Quarterly reports • Data collected from WITS • CONNECT Survey	• Quarterly reports • Data collected from WITS • CONNECT Survey
Quarter 4 (July – Sept)	• Quarterly reports • ParentingMT supplies survey • 2018 BRFSS data available • 2019 YRBS data available	• Quarterly reports • ParentingMT supplies survey • 2019 BRFSS data available • Annual Prevention Specialists/County Report Card	• Quarterly reports • ParentingMT supplies survey • 2020 BRFSS data available • 2021 YRBS data available • Annual Prevention Specialists/County Report Card	• Quarterly reports • ParentingMT supplies survey • 2021 BRFSS data available • Annual Prevention Specialists/County Report Card	• Quarterly reports • ParentingMT supplies survey • 2022 BRFSS data • 2023 YRBS data available • Annual Prevention Specialists/County Report Card
	Evaluation and Data Tracking Activities				

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Use and Communication of Evaluation Findings

Use and Communication

Evaluation findings will be used to monitor progress towards each grant's goals and objectives, while also answering evaluation questions. It will be used to identify areas in need of more active monitoring, while also helping reduce areas where data is over collected. The evaluation plan can be updated accordingly with these findings. The process and outcome evaluation findings will be available for stakeholders to view when available. The data found can be used to monitor progress through future evaluations for these grants through AMDD.

Due to Montana's frontier environment, the main method of communication between stakeholders is through email and phone. SAMHSA communication will be through SPARS, where all collected data for the Partnership for Success grant is reported annually. Block Grant data is reported to SAMHSA in WebBgas. AMDD and DPHHS will communicate via email, phone, and in-person. All other stakeholder communication is mainly through email and phone.

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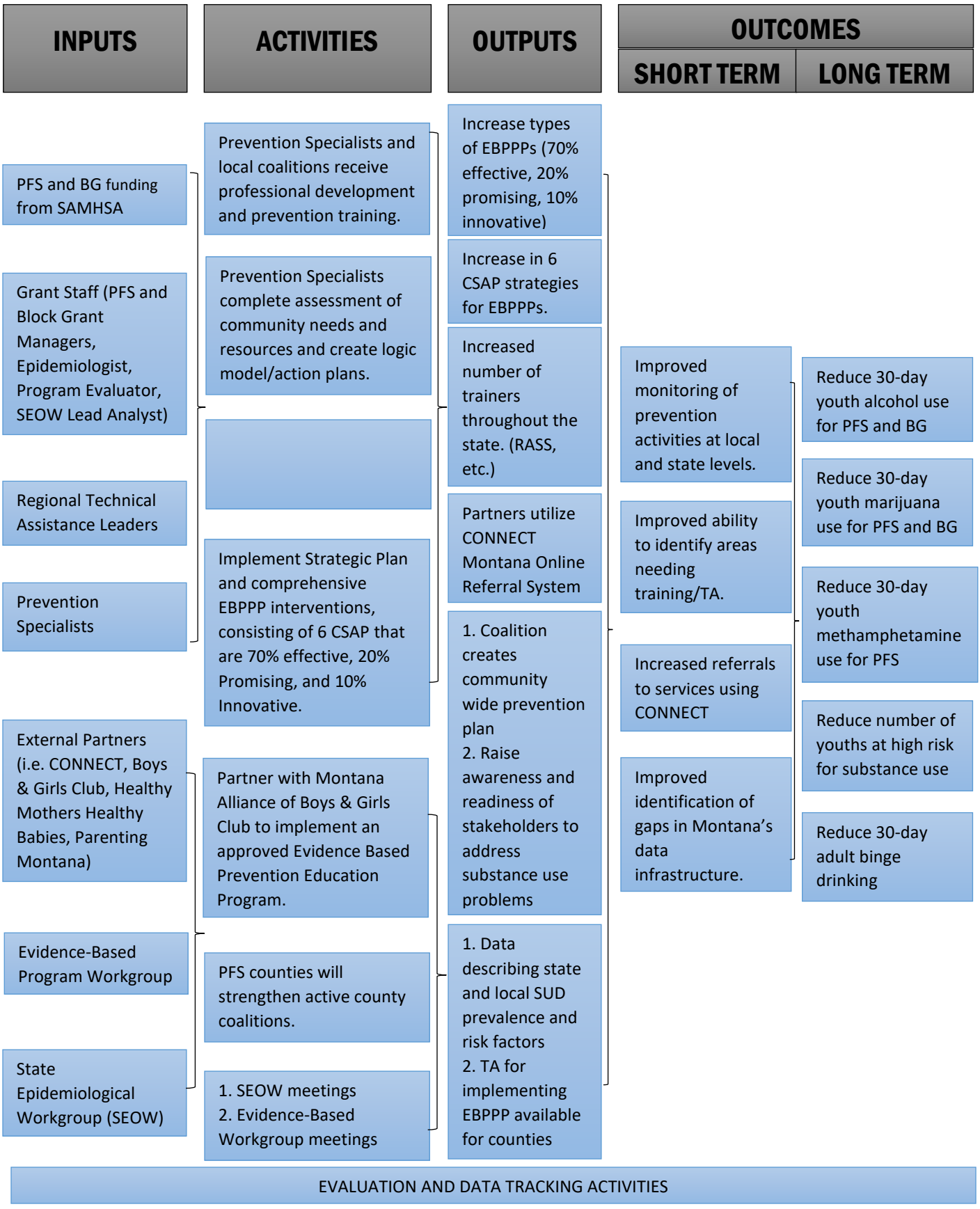


Report updated September 8, 2021

MONTANA

Evidence-Based Workgroup

Guide to Evidence-Based Substance Prevention

October 2017

MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services

In Partnership with -Addictive and Mental Disorder Division and Interagency Coordinating Council

Table of Contents

Introduction to Prevention Resource Center

State Advisory Council, State Epidemiology Outcomes Workgroup & Evidence-Based Workgroup

The Prevention Resource Center, in the Office of the Director of Department of Public Health and Human Services (DPHHS), works to raise public awareness about public health issues, including substance use, and how to prevent them statewide. A key function of the Prevention Resource Center is to coordinate the Interagency Coordinating Council (ICC), established in 1993. By Montana statute, the ICC includes the Attorney General, the Superintendent of Public Instruction, representation from private and non-profit prevention programs, the Montana Children's Trust Fund board, and agency directors from DPHHS, the Montana Board of Crime Control, the Department of Labor and Industry, and the Department of Transportation, among others.[1]

The duties of the ICC include:

- Creating a comprehensive and coordinated prevention program delivery system
- Developing interagency prevention programs and services that address the problems of at-risk children and families
- Studying financing options for prevention programs and services
- Ensuring that a balanced and comprehensive range of prevention services is available to children and families with specific or multi agency needs
- Assisting in the development of cooperative partnerships among state agencies and community-based public and private providers of prevention programs
- Developing, maintaining, and implementing benchmarks for State prevention programs[2]

A current priority identified by the ICC is youth alcohol, tobacco and drug use. However, this group does not have any direct state funding to implement prevention programs to address this or other priority areas. Instead, the ICC must work to coordinate efforts and leverage funds from participating agencies.

The ICC also organizes a number of key workgroups who are tasked with researching and providing guidance on key aspects of prevention efforts in the state. These groups include:

State Epidemiology Outcomes Workgroup: The State Epidemiology Outcomes Workgroup (SEOW) seeks to drive data-informed decision making on what the substance use disorder (SUD) problems in Montana are and where resources should be directed. The workgroup sets the foundation for SUD-related programs in Montana to measure outcomes. The SEOW is a required element for most, if not all, SAMHSA funded prevention grants.

Evidence-Based Work Group: The ICC also convenes an Evidence-Based Workgroup whose purpose is to assist prevention specialists and coalitions with identifying research- and evidence-based practices that are grounded in prevention science and, if implemented with fidelity and are culturally relevant, can achieve measurable outcomes and move the needle on curbing and addressing substance misuse and abuse.

[1] http://leg.mt.gov/BILLS/mca/2/15/2-15-225.htm
[2] IBID

Mission Statement

Assist Montana communities in selecting best fit evidence-based substance misuse and abuse prevention strategies for their unique community to address identified needs.

Vision Statement

Improve health and prevent substance misuse and abuse across the lifespan of all Montanans by implementing sustainable prevention programs and practices which are grounded in science, based on proven standards, use valuable resources effectively and efficiently, and are responsive to diverse cultural beliefs and practices.

Introduction

The PEW Charitable Trusts report *"How States Engage In Evidence-Based Policymaking – A national assessment"* states, "By focusing limited resources on public services and programs that have been shown to produce positive results, governments can expand their investments in more cost-effective options, consider reducing funding for ineffective programs, and improve the outcomes of services funded by taxpayer dollars"(1). The Prevention Evidence-based workgroup is focused on Activities A-E.

Evidence-Based Policymaking Activities Include:

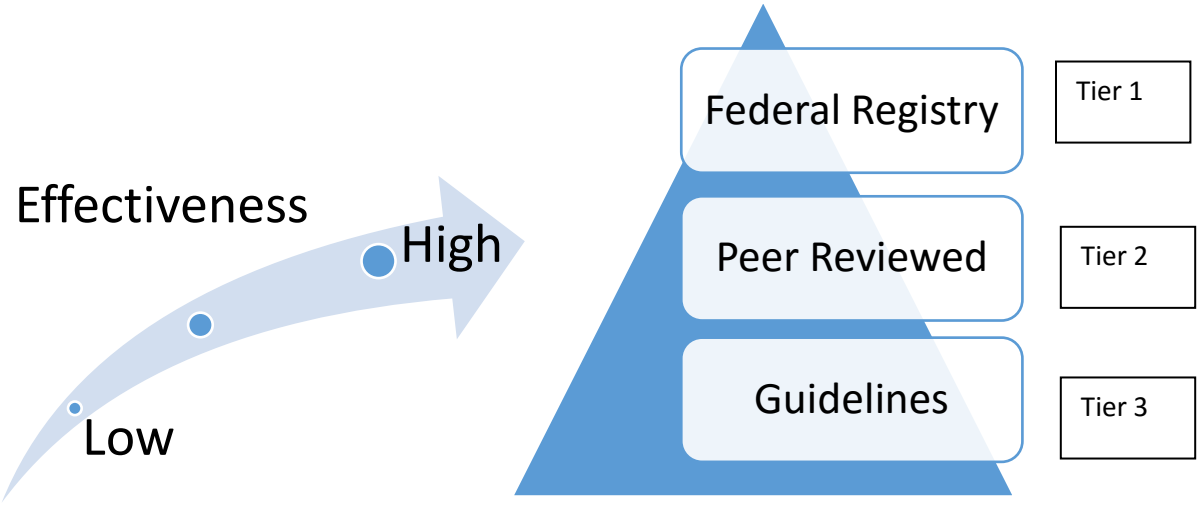
A) **Defining levels of evidence to allow state leaders to distinguish proven programs from those that have not been evaluated.**
B) **Inventorying state programs to help governments manage available resources strategically.**
C) **Comparing program costs and benefits allowing policymakers to weigh the costs of public programs against the outcomes and economic returns they deliver.**
D) **Reporting outcomes and program effectiveness to help policymakers identify which investments are generating positive results and use this information to better prioritize and direct funds**.
E) **Targeting funding to evidence-based programs, such as through a grant or contract, which can help states implement and expand these proven approaches.**
F) **Requiring action through state law, which includes administrative codes, executive orders, and statutes, to help states sustain support for evidence-based policymaking.**

[1] http://www.pewtrusts.org/en/research-and-analysis/reports/2017/01/how-states-engage-in-evidence-based-policymaking

Defining the Levels of Evidence

The Evidence Based Workgroup of Montana has adopted the Center for Substance Abuse Prevention's (CSAP's)/Substance Abuse Mental Health Services Administration's (SAMHSA's) operational definition of "evidence based," which states that a program's effectiveness must be supported by Tier 1) inclusion in a Federal registry of evidence-based interventions, Tier 2) publication in a peer-reviewed journal, or Tier 3) documentation based on guidelines. (See Figure 1)

Figure 1



Tier 1 -Inclusion in a Federal Registry of Evidence-based interventions

Standards:

1.1 – Strategy appears on a National registry of evidence based practices
1.2 – Strategy is based upon a theory of change that is documented in a clear logic model
1.3 – Proposed strategy implementation falls within acceptable deviation from original implementation design

Tier 1: Mapping Federal Registry Standards to a MT standard

(Effective, Promising, Researched)

The Evidence-based Workgroup reviewed several federal registries and determined that registries rank their programs using their own determined language standards for evaluating programs but have common underlying comparable rigorous principles. Using these principles, the workgroup developed a "simple" language standard to define levels of evidence. Figure 2 shows the mapping of several national database rating scale to equivalent MT rating standards.

- **Effective** - Programs having strong evidence that have been shown achieving outcomes are classified as "evidence-based" but may also be "best practice", "well supported", or "Model Program", as these categorizations demonstrate favorable long-term effects.

- **Promising** - Programs that have been shown effective through less rigorous evaluation methods are classified as "Promising" as this categorization demonstrates likely favorable short-term effects.

- **Researched**- Programs that have shown insufficient methodological rigor where the short-term effects could not be calculated, but correlational studies and/or outcome surveys exist. These are classified as, "Researched Based", "Researched Informed", and "Inconclusive" as this categorization demonstrates effects requiring further rigorous evaluations.

Figure 2 Crosswalk - National Evidence-Based Database to Montana Rating System

Evidence Based Indicator	MT Rating Continuum	Blue Prints	NREPP	NREPP Legacy	CA EB Clearinghouse	Crime Solutions & OJJDP
YES	Effective	Model Plus	Effective	3.0 or higher	Well Supported	Effective 
		Model			Supported	
YES	Promising	Promising	Promising	2.5 to 2.9	Promising	Promising 
NO	Researched	Researched Informed	Inconclusive	2.4 and Below		
NO	N/A	Opinion Informed	Ineffective		Fails to Demonstrate Concerning Practice	No Effect

Tier 2) Publication in a peer-reviewed journal

Standards:

2.1 - Strategy appears in a peer-reviewed publication with positive effects

2.2 - Strategy is based upon a theory of change that is documented in a clear logic model

2.3- Proposed strategy implementation falls within acceptable deviation from original implementation design

Tier 3) Documentation based on guidelines

Standards:

3.1 - Strategy has been effectively implemented in the past, multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects (Includes: Dates of implementation, Location and setting of implementation, Number of participants involved in each strategy implementation, Outcome data documenting measurable positive change)

3.2 - Strategy is based upon a theory of change that is documented in a clear logic model

3.3 - Proposed strategy implementation falls within acceptable deviation from original implementation design

Selecting Evidence Based Programs, Policies and Practices that Align with Community Needs

Following meeting the criteria for SAMHSA's operational definition of "evidence-based" as defined above, communities are also required to align their selection with their "Community Needs" as outlined through Community Fit, Feasibility, and Data Outcome Driven Measures.

Community Fit

Community Fit Criteria:

- Will the proposed strategy yield the listed short and long term outcomes?
- Are the proposed activities an appropriate match with the population served?
- Does it address the identified Risk/Protective Factors?

Feasibility (Capacity-Resources for Sustainability)

Feasibility addresses the process through which a prevention system becomes a norm and is integrated into ongoing operations. Sustainability is vital to ensuring that prevention values and processes are firmly established, that partnerships are strengthened, and that financial and other resources (staffing, time, resources) are secured over the long term.

Best practices recommend completing it in partnership with Prevention Specialists and Point Person at the location where the program will be implemented.

Ease of Sustainability Criteria	**RANK (1-5) WHERE 1= Low Support 5=High Support or NA(Not applicable=5)**
Prevention Values	
Administrative organizational support	
Reaches target domain	
Program shows high level of EB - ethical	
Program is relevant	
Processes	
Memorandum Of Understandings are in place-established-secured	
Availability of data to support	
Ongoing ability to evaluate ongoing need	
Continued fidelity of program implementation	
Financial Supports	
Cost of purchase	
Cost of specialized training	
Cost of technical assistance	
Cost of technology	
Human Supports	
Assigned point person	
Time commitment to roll-out program	
Staff with right skill-set	
Adequate number of staff	
Experience with relevant prevention interventions	
Experience with target population(s)	
Total Points	
High Support 61-90	
Medium Support 31 - 60	
Low Support 0 - 30	

Data Outcome-Driven Measures

- Does the program and/or selected strategy ….

    - address the prioritized issue?
    - focus on identified target population?
    - address short and long-term outcome measures? (Problem & Risk/Protective Factors)

The Evidence-based Workgroup's Mission is to assist Montana communities in selecting best fit evidence-based substance misuse and abuse prevention strategies for their unique community to address identified needs.

The Evidence-based Workgroup is available by request to assist in the selection process. The group meets quarterly and/or as requested. Any community can request these services by completing one of the following forms (below):

1) Request for Evidence-Based **Research** Program Identification- a program needs to be identified as the best-fit for the community's identified needs.

2) Request for Evidence-Based Program **Consideration and/or Modification**- a program has been identified and a community requests approval; or a program has been selected but a community wishes to implement only portions of the program. The workgroup will check to see if the evidence level rating must be modified, as it is not being implemented with full fidelity.

Once completed, please submit document to Vicki Turner, Director of the Prevention Resource Center and chair of the ICC (Interagency Coordinating Council) vturner@mt.gov.

Request for Evidence-Based **Research** Program Identification

Date:

Community: Coordinator Name:

Grant Funding Sources:

A. Priority SUBSTANCE Abuse Problem Being Addressed (Consumption/Consequence):

B. Target Population:

C. Identified Factors:

Risk Factors:

Protective Factors:

Other Identified Intervening Variables/Community Level Indicators:

D. Measures and Sources:

Sources of Data to Support Identified Risk/Protective Factor and/or Intervening Variables/Community Level Indicators:

Qualitative (Examples: Focus Groups):

Quantitative (Examples: MT Prevention Needs Assessment, Youth Risk Behavior Survey):

E. Relevance

How will addressing this need/gap serve as a foundation for improving the overall outcomes in your community?

F. Searched the following EB databases:

Check	Resource Links:	National Evidence-Based Database
	http://www.blueprintsprograms.com	Blueprints
	www.ojjdp.gov/mpg	Office of Juvenile Justice and Delinquency Prevention Model Program Guide
	http://www.crimesolutions.gov/TopicDetails.aspx?ID=69	Crime Solutions
	http://www.cebc4cw.org	California Evidence-Based Clearinghouse
	http://nrepp.samhsa.gov/AdvancedSearch.aspx	Substance Abuse and Mental Health Services Division – National Registry of Evidence-Based Program Practices

G. Workgroup Response:

Request for Evidence-Based **Research** Program Consideration and/or Modification

Date:

Community: Coordinator Name:

Grant Funding Sources:

A. Priority SUBSTANCE Abuse Problem Being Addressed (Consumption/Consequence):

B. Target Population:

C. Identified Factors:

Risk Factors:

Protective Factors:

Other Identified Intervening Variables/Community Level Indicators:

D. Measures and Sources:

Sources of Data to Support Identified Risk/Protective Factor and/or Intervening Variables/Community Level Indicators:

Qualitative (Examples: Focus Groups):

Quantitative (Examples: MT Prevention Needs Assessment, Youth Risk Behavior Survey):

E. Relevance

How will addressing this need/gap serve as a foundation for improving the overall outcomes in your community?

F. Name of the Strategy/Evidence-based Program/practice/policy:

Check one box only:

□ **Federal Registry** (it appears in a federal registry of Evidence-based programs
Name of Registry: Rating:

□ **Peer Reviewed Journal** (it has been positively evaluated in a peer review journal)
Name of Journal: URL Link Address:

□ **"Other Guidelines"** (it is evidence-based according to "other documented sources")

Logic Model: Evaluation: Panel Review:

□ **Promising Practice** (it does not meet any of the above definitions, but there is preliminary evidence of effectiveness available)

□ **No Evidence** (there is no evidence of this strategy's effectiveness available)

G. Community Engagement Process

Please provide documentation that demonstrates how your community identified the program as the best-fit for your community.

(Coalition minutes showing the following process occurred with community members)

a. Presented Data
b. Analyzed data
c. Assessed Community Resources
d. Assessed capacity
e. List of all programs under consideration and why the one chosen was the best fit.

H. Community Buy-in

a. Are you collaborating with other organizations to cover costs of this expense? Please briefly share those organizations and the role you/they will play in sustainability.

I. Modification on Implementation of an Evidence-based Program/Practice/Policy?

Please state why you feel it needs to be modified and how you came to this conclusion?

Define how the strategy will be modified.

I. Additional Comments:

J. Workgroup Response:

Evidence-Based Workgroup Team Members

Evidence-Based Workgroup team members are responsible for understanding the state logic model and grant priorities. Their tasks include identifying and selecting evidence-based interventions, reviewing and making recommendations on community prevention plans, and approving community strategic prevention plans. Members are recruited and trained. The group operates under the state advisory council (ICC). The group is also responsible for evaluating interventions being implemented across the state.

a. The workgroup should consist of 8-10 members
b. All members received training and technical assistance on skills needed, which include:
    i. Ability to locate, read and understand research
    ii. Ability to develop/approve a Logic Model with fidelity and rigor
    iii. Knowledge of national database language and standards
    iv. Knowledge of rigor (valid & reliable) and evidence-based process
c. Minimum of 5 years of experience in the Science of Prevention

Members Include:

Christine Steele Prevention Program Manager DPHHS- Addictive and Mental Disorder Division PO Box 202905 Helena, MT 59620-2905 (406) 444-1202 csteele@mt.gov	**Vicki J. Turner, Director** Prevention Resource Center PO Box 4210 Helena, MT 59604-4210 (406) 444-3484 vturner@mt.gov	**Dan McGoldrick** Prevention Contract Administrator Boyd Andrew Management Services (406) 447-3274 danmcgoldrick@boydandrew.com
Bethany Fatupaito, MPH Project Director, Partnership for Success Grant (TiPI) Rocky Mountain Tribal Leaders Council 711 Central Avenue, Suite 220 Billings, MT 59102-5889 (406) 252-2550 bethany.fatupaito@rmtlc.org	**Rachel Gooen, MSW** 5th House Consulting 117 West Broadway Missoula, MT 59802 (406) 360-7685 rachel@5thhouseconsulting.com	**Barbara Bessette** Prevention Specialist Gateway Community Services 26 4th Street North Great Falls, MT 59401 (406) 727-2512 barbarab@gatewayrecovery.org
Coleen Smith, Executive Director Youth Connections Coalition P O Box 4572 Helena, MT 59604 (406) 324-1032 coleen@youthconnectionscoaltion.org	**Mackenzie Antila** SAMHSA/CSAP Prevention Fellow Prevention Resource Center, DPHHS PO Box 4210 Helena, MT 59604-4210 (406) 444-3023 mantila@mt.gov	**Morgan Witzel** Project Coordinator, Partnership for Success Grant (TiPI) Rocky Mountain Tribal Leaders Council 711 Central Avenue, Suite 220 Billings, MT 59102-5889 (406) 252-2550 morgan.witzel@rmtlc.org

Prevention Specialists

Available in every county is a local Prevention Specialist who can help guide a community in the process of selecting and/or completing any of these forms.

Please visit http://dphhs.mt.gov/Portals/85/amdd/documents/Substance%20Abuse/PSCountyList.pdf

Glossary

Evidence-based prevention strategies – Programs or policies that have been evaluated and demonstrated to be effective in preventing health problems based upon the best-available research evidence, rather than upon personal belief.

Evidence-based practice – 1) Making decisions based on the best available scientific and rigorous program evaluation evidence; 2) applying program planning and quality improvement frameworks; 3) engaging the community and stakeholders in assessment and decision making; 4) adapting evidence-based interventions for specific populations or settings; and 5) conducting sound evaluation.[3]

Peer-Reviewed Literature – articles and reports that have gone through a formal process to assess quality, accuracy, and validity

[3] Brownson RC, Baker EA, Leet TL, Gillespie KN, True WR. Evidence-Based Public Health. 2nd edition. New York (NY): Oxford University Press; 2011.

Table Definitions

***For the Complete Listing of Programs parsed by Domain – please email csteele@mt.gov**

Domains	(Community, School, Peer/Individual, After-School, College, Outpatient)
Geographic Location	National Databases utilize these categories: Urban, Suburban, Frontier/Rural/Tribal MT will not use Urban/Suburban classifications MT will use Frontier, Rural and Tribal MT defines three Urban/Rural classifications of populations: Small Metro <= 157,048 Micropolitan < = 114,181 Noncore <= 19,052
Institute Of Medicine (IOM) Classification System	The IOM identifies the following three categories based on level of risk: Universal, Selective, and Indicated. **Universal-** Universal interventions target the general population and are not directed at a specific risk group. Addresses an entire population. **Selective-** Selective interventions target those at higher-than-average risk for substance abuse; individuals are identified by the magnitude and nature of risk factors for substance abuse to which they are exposed. Selective prevention measures target subsets of the total population that are considered at risk for substance abuse by virtue of their membership in a particular segment of the population. **Indicated-** Indicated interventions target those already using or engaged in other high-risk behaviors to prevent heavy or chronic use. Indicated prevention measures are designed to prevent the onset of substance abuse in individuals who do not meet the medical criteria for addiction, but who are showing early danger signs.
Target Audience	By age or Childhood, Adolescent(Early, Late), Young Adult, Families, based on who this curriculum/program is for
Risk/Protective Factors	Factors based on Montana Prevention Needs Assessment (PNA) Risk Factors: Conditions for an individual, group, or community that increase the likelihood of a substance abuse problem. Protective Factors: Conditions for an individual, group, or community that decrease the likelihood of substance abuse problems and buffer the risks of substance abuse.
Evidence Level	Strong evidence means that the positive outcomes assessed are attributable to the intervention rather than to extraneous events, and that the intervention reliably produces the same pattern of positive outcomes in similar populations and contexts.
Cost	Anticipated costs to implement the program (materials, travel, training, staff, etc.)
Cost Effectiveness	Rate of return on investment, cost of program versus long term cost savings with intervention
Description	Brief description of the program
Reference Links	Link where to find further information on identified program

List of Evidence-Based Programs

The following list is an abridged version. For a more complete list with all information listed by Domains, please email csteele@mt.gov.

The Unabridged version contains all the information defined in the table definitions listed above.

Programs sorted by domains and include:

- Community
- School
- Family
- Rural - Frontier
- Tribal

The unabridged version includes the following additional information:

- Geographic Location
- Institute Of Medicine (IOM) Classification System
- Target Audience
- Risk/Protective Factors
- Evidence Level
- Cost of the program
- Cost Effectiveness
- Description
- Reference Links

Program Name	Evidence Level	Program Setting/Domain	Geographic Location R&F/T
Name of the Approved Program	**A continuum of evidence quality, which ranges from weak (researched) to strong (Effective)** **A Legacy program** has not been re-evaluated by NREPP based on new rating standards	**Who is the social target audience- where or to whom program would be used with**	**Urban - N/A in MT** **Suburban - N/A in MT** **Frontier/Rural** **Tribal**
Achievement Mentoring	Promising	School	N/A
Across Ages	Promising	Community	Suburban, urban
Active Parenting Now	Promising	Family	Rural
Alcohol.Edu	Effective	School	Rural, Suburban
Alcohol Literacy Challenge	Effective	School	Suburban
Alcohol: True Stories Hosted by Matt Damon	Researched	School	Suburban
All Stars	Promising	School/After-School	Rural/Suburban
Alcohol Misuse Prevention Study (AMPS)	Promising	School	Suburban
American Indian Life Skills	Promising	School/Community	Tribal
Bicultural Competence Skills	Promising	School/After-School	Tribal
Brief Alcohol Screening and Intervention of College Students (BASICS)	Effective	College	Suburban, Urban
Class Action	Effective	School/After-School	Suburban, Tribal
Climate Schools: Alcohol and Cannabis Course	Promising	School	Urban
Communities Mobilizing for Change on Alcohol	Researched	Community	Suburban
Communities that Care	Effective	Community	Rural, Suburban
Coping and Support Training (CAST)	Effective *National Institute of Health funded study	School	Urban/Suburban/Rural/Frontier /Tribal
Creating Lasting Family Connections	Effective/Promising	Community/Family	Urban, Suburban, Rural/Frontier

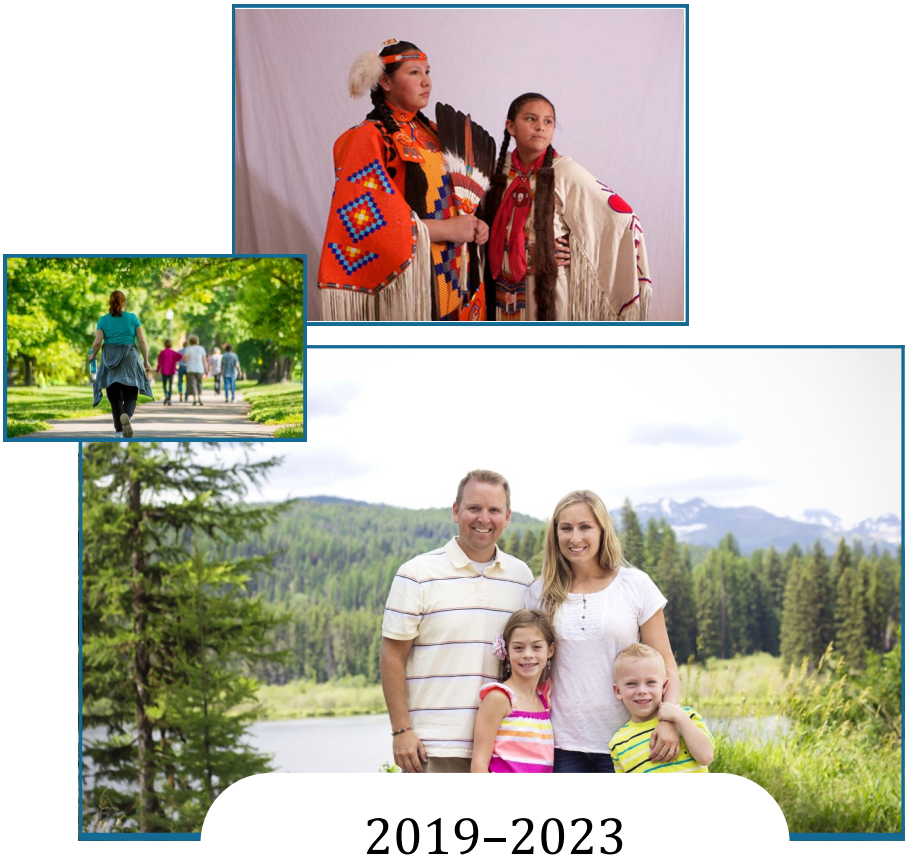
Program Name	Evidence Level	Program Setting/Domain	Geographic Location R&F/T
Name of the Approved Program	**A continuum of evidence quality, which ranges from weak (researched) to strong (Effective)** **A Legacy program** has not been re-evaluated by NREPP based on new rating standards	**Who is the social target audience- where or to whom program would be used with**	**Urban - N/A in MT** **Suburban - N/A in MT** **Frontier/Rural** **Tribal**
Drugs: True Stories	Researched	School	Suburban
Early Risers	Effective	Family/School	Urban/Suburban/Rural/Frontier
Effekt	Promising	Community/School	N/A
Family Matters	Effective	Family	Urban/Suburban/Rural/Frontier
Family-School Partnership Intervention to Reduce Risk of Substance Use	Promising	School	Urban
Family Check up for Adolescents	Promising	Community/Family/School	Urban/Suburban/Rural/Frontier/Tribal
Good Behavior Game	Effective	School	Urban/Rural
Guiding Good Choices	Effective/Promising	School/Family	Rural/Frontier
Hip-Hop 2 Prevent Substance Abuse and HIV	Promising	School/Community	Urban
Hero Project: cultural/adventure rites of passage	Legacy-Effective	Community	Urban/Rural/Frontier or Tribal
InShape	Promising	School-College	Urban/Suburban/Rural/Frontier
Keepin It Real	Promising/ No effects	School	Urban
Life Skills Training (LST)	Effective	School	Urban/Suburban/Rural/Frontier
Lions Quest Skills for Adolescence	Promising	School	Urban/Suburban/Rural/Frontier
Media Detective	Promising	School	Suburban/Rural/Frontier
Media Ready	Promising	School	Suburban/Rural/Frontier/Tribal
Master Mind	Promising	School	Rural/Frontier/Tribal
Open Circle	Promising	School	Rural/Suburban/Tribal

Program Name	Evidence Level	Program Setting/Domain	Geographic Location R&F/T
Name of the Approved Program	**A continuum of evidence quality, which ranges from weak (researched) to strong (Effective)** **A Legacy program** has not been re-evaluated by NREPP based on new rating standards	**Who is the social target audience- where or to whom program would be used with**	**Urban - N/A in MT** **Suburban - N/A in MT** **Frontier/Rural** **Tribal**
Positive Action	Effective	School (Family/Community options)	Urban/Suburban/Rural/Frontier
Prime for Life	Legacy - Effective	School/Community	Rural/Suburban/Tribal
Project ALERT	Promising	School	Urban/Suburban/Rural/Frontier
Project Northland	Promising	School/Community	Urban/Suburban/Rural/Frontier
Project SUCCESS	Legacy - Effective	School/Community	Urban/Suburban/Rural/Frontier
Project Towards No Drug Abuse	Effective	School	Urban/Suburban/Rural/Frontier
PROSPER	Promising	Community/School	Urban/Suburban/Rural/Frontier
Protecting You/Protecting Me	Legacy - Effective	School	Suburban/Rural/Frontier (adaptation for Tribal)
Raising Healthy Children	Promising	School	Suburban
Reality Tour	Legacy - Effective	Community	Suburban
Reconnecting Youth: A Peer Group Approach to Building Life Skills	Legacy - Effective	School	Suburban
Red Cliff Wellness School Curriculum	Researched	School/Community	Rural/Frontier, Tribal

Program Name	Evidence Level	Program Setting/Domain	Geographic Location R&F/T
Name of the Approved Program	**A continuum of evidence quality, which ranges from weak (researched) to strong (Effective)** **A Legacy program** has not been re-evaluated by NREPP based on new rating standards	**Who is the social target audience- where or to whom program would be used with**	**Urban - N/A in MT** **Suburban - N/A in MT** **Frontier/Rural** **Tribal**
Residential Student Assistance Program	Legacy - Effective	Community	Suburban
Ripple Effects Whole Spectrum Intervention System	Legacy - Effective	School	Suburban/Rural/Frontier
Rock in Prevention, Rock PLUS	Legacy - Promising	Family/School	Rural/Frontier
Say It Straight (SIS)	Effective	School/Community	U/S/R&F
Smart Leaders	Promising	Community	Urban/Suburban
Social Decision Making / Problem Solving	Promising	School	Suburban
SODAS City	Effective	Family/ School/Community	Urban/Suburban
SPORT Prevention Plus Wellness	Promising	School	N/A
STARS (Start Talking Alcohol Risks Seriously) for Families	Effective	School/after-school	Suburban/Rural/Frontier
Staying Connected with Your Teen	Promising	Community/Family	Urban/Suburban
Strengthening Families Program For Parents and Youth 10-14	Promising	Community/School/Family	Urban/Suburban/Rural/Frontier

Program Name	Evidence Level	Program Setting/Domain	Geographic Location R&F/T
Name of the Approved Program	**A continuum of evidence quality, which ranges from weak (researched) to strong (Effective)** **A Legacy- program** has not been re-evaluated by NREPP based on new rating standards	**Who is the social target audience- where or to whom program would be used with**	**Urban - N/A in MT** **Suburban - N/A in MT** **Frontier/Rural** **Tribal**
Students Leading Students	Promising	School	Urban/Suburban/Rural/Frontier
Too Good for Drugs-Middle	Promising	School	Suburban/Rural/Frontier/Tribal
Training for Intervention Procedures (TIPS) for the University	Legacy - Effective	College	Urban/Suburban/Rural/Frontier
Teen Intervene	Effective	School/Outpatient	Urban/Suburban
unique YOU	Promising	Community/School	N/A
Youth Message Development	Effective	School	N/A

Montana State Health Improvement Plan



2019–2023

Healthy Living...Healthy Futures for Montana

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

Updated February 2021

A MESSAGE FROM THE DIRECTOR

Montana is an incredible place to live, work, and raise a family. Healthy people and healthy families are essential for thriving communities and a robust economy.

My vision for Montana, as the Director of the Department of Public Health and Human Services, is "Healthy People, Healthy Communities, Healthy Future." We plan to realize this vision by decreasing health disparities; increasing access to timely, affordable, and effective health services; strengthening prevention efforts to promote health and well-being; and improving the public health system capacity.

Montana has made great strides in promoting health equity and improving population health, but we can always do better to help all Montanans achieve their fullest potential. The 2017 State Health Assessment revealed that Montanans still face challenges, particularly in five priority areas that we have chosen to emphasize in the 2019-2023 State Health Improvement Plan. Those priority areas include:

- Behavioral health;
- Chronic disease prevention and self-management;
- Motor vehicle crashes;
- Healthy mothers, babies, and youth; and
- Adverse Childhood Experiences.

Finally, we know we cannot do this work alone. Over the next five years, we will emphasize creative collaborations with community partners across Montana to achieve the objectives outlined in this State Health Improvement Plan. We also call on the citizens of Montana to take action to maintain and improve their own health and that of their families.

I thank DPHHS staff and partners who worked together to bring you this information.

Working with you for a healthier Montana,

Sheila Hogan

Sheila Hogan, Director
Montana Department of Public Health and Human Services

TABLE OF CONTENTS

INTRODUCTION

Creating and maintaining a healthy Montana is critical to Montana's continued success. Healthy children are better students, healthy adults make a more productive work force, and healthy seniors enjoy more satisfying retirement years. A healthy population is essential to a strong economy, both statewide and in all our communities.

Montana has made progress improving the population's health. We are more physically active and less obese than the U.S. overall. We have made significant reductions in the use of commercial tobacco products among youth. However, many challenges, including substance abuse and mental health issues, still exist.

To ensure the positive health trends are not reversed and to create a healthier Montana, the Public Health and Safety Division (PHSD) of the Montana Department of Public Health and Human Services (DPHHS) initiated a strategic planning process in 2017. Twenty-four members, representing healthcare and public health agencies across the state, served on the steering committee for this process. This steering committee is called the State Health Improvement Coalition and it developed the five-year State Health Improvement Plan (SHIP) contained in this report.

The State Health Improvement Coalition operates under the following mission and guiding principles:

Mission: To protect and improve the health of every Montanan through evidence-based action and community engagement.

Guiding Principles:

- Use evidence-based strategies to address health priorities.
- Use strategies and actions that encourage connections across our communities.
- Promote health equity and value differences in cultures, attitudes, and beliefs.
- Strengthen our public health system to deliver results.

The State Health Improvement Coalition worked together to determine the top health priorities based on available data from the 2017 State Health Assessment, input from stakeholders, and a prioritization matrix.

This document was released for public comment during December 2018 and originally published in February 2019, and re-released in January 2020 to incorporate grammatical edits and refined objectives for improved monitoring and evaluation; several objectives in the version published in February 2019 had yet to have baseline data calculated and targets established, both of which were then included for most objectives. It was updated again in February 2021 with the remaining baselines and targets, as well as objectives that have been added or modified to improve tracking. Details of any updates to the objectives can be found in the most recent Annual Report.

The health priority areas identified to address over the next five years are:

1. Behavioral health, including substance use disorders, mental health, suicide prevention, and opioid misuse;
2. Chronic disease prevention and self-management;
3. Motor Vehicle Crashes (MVCs);
4. Healthy mothers, babies, and youth; and
5. Adverse Childhood Experiences (ACEs).

Each section of the plan describes the health priority, goals, objectives, evidence-based strategies, and key partners. The strategies are categorized in four action areas: prevention and health promotion, clinical/health systems, policy, and health equity.

Supporting Health Equity

The 2017 Montana State Health Assessment (SHA)[1] identified significant health disparities, particularly among American Indian communities. American Indians in Montana have higher mortality rates for many of the leading causes of death, significantly higher premature mortality, and higher prevalence rates for many risk factors and diseases compared to the state overall. Many of Montana's tribes are working on or have completed their Tribal Health Assessments and their Tribal Health Improvement Plans. These plans identify specific health priorities, strategies, and measures that each tribe will be focusing on to improve the health of their communities, many of which are the same as the health priorities outlined in the SHIP. DPHHS is committed to collaborating with the tribes and the Urban Indian Health Centers to address health equity and to improve the health status of American Indian communities. The 2019–2023 SHIP provides a common health agenda and framework for improving the health of all Montanans.

Healthy People 2020

The U.S. Department of Health and Human Services provides science-based, 10-year national objectives for improving the health of all Americans. The current objectives are called *Healthy People 2020*. Healthy People 2020 establishes targets that are measurable, achievable, and applicable at the national, state, and local levels. The 2019–2023 SHIP used Healthy People 2020 targets as benchmarks to establish its objectives. Each objectives section within the SHIP will have a Healthy People 2020 column and the Healthy People 2020 target next to an objective that aligns with a Healthy People (HP) 2020 objective.[2]

Collective Impact

Counties, tribes, and hospitals have identified specific community health priorities and community health improvement plans to address these priorities. It is not expected that counties, tribes, and other partners will focus on each specific priority area and the strategies described in the SHIP. However, through collective action of these organizations in collaboration with their community partners, Montana will make progress to address the health priority areas identified in the SHIP.

Monitoring and Evaluation

The SHIP is designed to be a living document, and will be monitored and updated annually as needed. For more information about SHIP monitoring and evaluation, visit https://dphhs.mt.gov/ahealthiermontana.

Priority Area 1

Behavioral Health

This Priority Area Includes:

- Mental Health
- Substance Use Disorders
- Unintentional Poisonings
- Opioid Misuse
- Suicide Prevention

The Problem:

Poor mental well-being affects thousands of Montanans. One in ten Montana adults (nearly 84,000) report frequent mental distress with 14 or more days of poor mental or emotional health in the past month.[3] Further, 41,000 Montana adults have serious mental illness.[4] Suicide, a mental health crisis, continues to affect every Montana community. Suicide-related deaths in Montana are two times higher than the U.S. An average of 240 suicide deaths occurred each year in Montana from 2011-2015.[5] The suicide rate was significantly higher in rural counties (population less than 10,000) compared to micropolitan (population between 10,000 and 49,999 people) counties.[6] The proportion of American Indian high school students who reported that they had attempted suicide in the past year was nearly two times higher (18%) than youth overall in Montana (10%).[7]

Nearly 64,000 Montana adults struggle with substance use disorder (SUD).[8] Alcohol is the most commonly abused substance in Montana. Use of illicit drugs like marijuana, cocaine, or heroin in Montana follows similar trends as the U.S. Methamphetamines continue to be a major concern in Montana; however, data regarding usage are limited, particularly among Montana's adult population. Among Montana youth, 2.2% of high school students reported having used methamphetamines during their lifetime.[7] Opioids are the leading cause of drug overdose deaths in Montana, accounting for 44% of all drug overdose deaths.

Access to treatment for both SUD and mental health is limited in Montana. Between 2015 and 2016, an estimated 73,500 Montanans aged 12 years and older (8%) needed but did not receive treatment for substance use in the past year.[8] From 2010 to 2014, only 39% of adolescents aged 12 to 17 years with a Major Depressive Episode received treatment within the last year.[9]

It is vital that health care providers are educated on delivery of care from a trauma-informed perspective, particularly in regards to historical trauma within the American Indian communities. The U.S. Administration for Children and Families defines historical trauma as "multigenerational trauma experienced by a specific cultural, racial, or ethnic group."[41] Trauma-informed care emphasizes "understanding, recognizing, and responding to the effects of all types of trauma in order to provide physical, psychological, and emotional safety for both consumers and providers."[42]

Goals:

1. Improve access to timely, affordable, and effective behavioral health services.
2. Prevent and treat depression, anxiety, and other mental health conditions.
3. Decrease the prevalence and adverse consequences of SUD.
4. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.
5. Decrease overdoses and deaths associated with prescription and illicit opiates through coordination of prevention, monitoring, enforcement, treatment, and recovery services.
6. Decrease behavioral health disparities among American Indian communities.
7. Support steps toward the integration of physical and behavioral health care at the community level.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease the proportion of adults who report frequent mental distress (≥14 days in past month with poor mental health status) from 10.4% to 9.9% (Baseline: MT BRFSS, 2016)	
2. Decrease percentage of high school students who report binge drinking in the past month from 17.6% to 16.7% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of high school students who attempted suicide in the past year from 9.5% to 9.0% (Baseline: MT YRBS, 2017)	X
4. Decrease past month alcohol use from 9.9% to 9.4% and illicit drug use from 10.0% to 9.5% among adolescents aged 12 to 17 years (Baseline: MT NSDUH, 2014-2015 and 2013-2014)	X
5. Decrease the proportion of adults who report binge drinking in past 30 days from 19% to 18% (Baseline: MT BRFSS, 2016)	X
6. Decrease opioid overdose death rate from 4.2 per 100,000 people to 3.8 per 100,000 people (Baseline: MT Office of Vital Statistics, 2016)	

Objectives to Improve Health Equity: By 2023

	HP 2020:
1. Decrease proportion of American Indian adults who report frequent mental distress (≥ 14 days in the past month with poor mental health status) from 15.4% to 14.6% (Baseline: MT BRFSS, 2016)	
2. Decrease percentage of American Indian high school students who report binge drinking in the past month from 22% to 21% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of American Indian high school students who attempted suicide in the past year from 18% to 17% (Baseline: MT YRBS, 2017)	X
4. Decrease the proportion of American Indian adults who report binge drinking in past 30 days from 20% to 19% (Baseline: MT BRFSS, 2016)	X

Prevention and Health Promotion Strategies:

- Implement evidence-based strategies in the Montana Suicide Prevention Plan.
- Increase the number of communities implementing the “Communities That Care” model to prevent underage substance use.
- Promote tobacco-free behavioral health programs.
- Implement a statewide public education campaign/media campaign that includes harm reduction, reducing stigma, proper storage and disposal of prescription medications, and awareness of the risks and protective factors to reduce adolescent substance use (such as binge drinking and prescription drug misuse).
- Increase awareness of and support for prescription drop boxes and disposal bags statewide.
- Support local and tribal health departments and non-profit organizations in Montana communities to implement evidence-based Opioid Use Disorder/SUD prevention activities.
- Retain Medicaid expansion.
- Increase access to behavioral health professionals within schools for youth with mental health and substance use needs.

Clinical Strategies:

- Promote routine screening for mental illness, anxiety, depression, SUD, and suicidal ideation in primary care and other medical settings using evidence-based screening tools (i.e. Screening, Brief Intervention, and Refer to Treatment, Alcohol Use Disorders Identification Test, Patient Health Questionnaire, Generalized Anxiety Disorder, and the Columbia Suicide Severity Rating Scale).
- Promote primary care-based interventions and, when appropriate, referrals and engagement in specialty services.
- Increase access to integrated behavioral health services and medical care, including telehealth and increased workforce, particularly in rural and frontier communities.
- Increase and promote use of evidence-based medication-assisted SUD treatment services for SUDs and opioid addiction.
- Increase access to SUD services for pregnant women with SUDs.
- Promote tobacco screening and cessation services and products in behavioral health, primary care, and other health settings.
- Increase training in Adverse Childhood Experiences (ACEs) and trauma-informed care among medical and behavioral health professionals.
- Increase the use of peer recovery supporters as a cost-effective way to improve the timeliness of entry to care and engagement in care throughout the treatment course, and to reduce recidivism after discharge from inpatient or residential treatment and incarceration.
- Train and increase number of Licensed Addiction Counselors and dually-licensed mental health and substance use providers and peer supporters.
- Increase the number of providers who have obtained the required training to prescribe buprenorphine (a DEA x-waiver). Buprenorphine is one of the three FDA-approved medications used to treat opioid addiction as Medication Assisted Treatment (MAT).

Alcohol is the most commonly abused substance in Montana.

Policy Strategies:

- Develop strategies to work across Montana's behavioral health system (mental health and SUD) to align payment reform, address workforce shortages, identify access barriers, ensure rapid and effective crisis response, and provide treatment in the least restrictive environment.
- Increase collaboration and successful "warm handoffs" for individuals admitted to and discharged from state-operated facilities, hospitals, residential behavioral health/psychiatric facilities, and community-based healthcare providers to lower annual readmission rates and to serve individuals in their own communities whenever possible.
- Increase the use of certified behavioral health peer specialists in recovery support to improve timeliness of entry to care and engagement in treatment and to reduce repeat hospitalizations and incarcerations.
- Increase direct collaboration and coordination of services between the SUD and mental health care system and the criminal justice and corrections system.
- Support administrative and legislative policies to increase prescribing according to the Centers for Disease Control and Prevention guidelines.
- Support policies requiring pharmacists to check identification before dispensing narcotics.
- Better utilize the Montana Prescription Drug Monitoring System to prevent over-prescribing of opioids or unintended drug-drug interactions.
- Improve data surveillance of suicide deaths in Montana through participation in the National Violent Death Review System.

Health Equity Strategies:

- Expand culturally relevant behavioral health services for diverse and health disparate populations (American Indian, LGBTQ, veterans, low income, rural, and frontier).
- Increase wraparound support services to individuals receiving or needing behavioral health services (crisis stabilization, care coordination, and recovery support).
- Increase number of integrated behavioral health programs providing SUD services who can access Medicaid reimbursement, including supporting tribally-operated clinics, Urban Indian Health Centers, FQHCs, Rural Health Clinics, and hospitals.
- Foster collaboration, particularly between frontier and rural areas and larger urban centers, to improve continuum of care in communities.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Board of Behavioral Health
- Board of Medical Examiners
- Board of Medicine
- Board of Pharmacies
- Business Leaders
- Community Prevention Partners
- Corrections
- Department of Justice (DOJ)
- DOJ Division of Criminal Investigations
- DPHHS Addictive and Mental Disorders Division
- DPHHS Prevention Resource Center
- DPHHS Public Health and Safety Division
- Department of Revenue
- Department of Transportation
- DUI Task Forces
- Federal Qualified Health Centers
- Hospitals
- Indian Health Service
- Law Enforcement Agencies
- Licensed Mental Health Centers
- Local Advisory Councils
- Local Boards of Health
- Local Health Departments
- Mental Health America
- Montana Association of Counties
- Montana Behavioral Health Association
- Montana Chemical Dependency Center
- Montana Healthcare Foundation
- Montana Hospital Association
- Montana Medicaid
- Montana Medical Association
- Montana Nursing Care Center
- Montana Peer Support Network
- Montana Pharmacy Association
- Montana Primary Care Association
- Montana Public Health Association
- Montana State Hospitals
- Montana State University-Mental Health Research Center
- National Alliance on Mental Illness Montana
- Open Aid Alliance
- Opioid Treatment Programs
- Policy Leaders
- Psychiatric Residential Treatment Facilities
- Public Health Prevention Specialists
- Recovery Support Groups
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Rural Health Clinics
- Schools
- Service Area Authorities
- Tribal Health Departments
- Urban Indian Health Centers
- Veterans Affairs

Priority Area 2

Chronic Disease Prevention and Self-Management

This Priority Area Includes:

- Tobacco Use Prevention and Cessation
- Obesity/Overweight Prevention
- Other Risk Factors for Chronic Disease

The Problem:

Much of the chronic disease burden is attributable to a short list of key risk factors, including tobacco use, obesity, physical inactivity, and poor nutrition. Tobacco use remains the leading cause of preventable death, with 1,600 tobacco-related deaths occurring in Montana each year.[13] Twenty-six percent of Montana adults and 33% of Montana youth currently use some type of tobacco product.[12, 7] This number is even higher for American Indians at 43% for adults and 40% for youth.[12, 7] Obesity results from a combination of poor dietary patterns and physical inactivity. More than one in ten Montana youth (12%) were obese in 2017 and one in four Montana adults (26%) in 2016.[7, 3] Again, this rate is much higher for Montana's American Indian population at 20% for youth and 32% for adults.[7, 3] Seventy-five percent of Montana adults and 72% of Montana youth do not meet the national physical activity recommendations.[7, 14] Montana ranks 46th in the nation for colorectal cancer screening, with only 62% of Montanans up-to-date with screening.[3]

Goals:

1. Prevent commercial tobacco use among youth and adults.
2. Make active living and healthy eating easy, safe, and accessible everywhere Montanans live, work, learn, and play.
3. Increase awareness and decrease prevalence of modifiable risk factors for chronic disease.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease the percentage of Montana adults who currently use tobacco from 26% to 24% (Baseline: MT BRFSS, 2016)	X
2. Decrease the percentage of Montana high school students who currently use tobacco from 33% to 29% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of Montana adults who are currently obese from 26% to 23% (Baseline: MT BRFSS, 2016)	X
4. Decrease the percentage of Montana high school students who are currently obese from 12% to 9% (Baseline: MT YRBS, 2017)	X
5. Increase the percentage of Montana men and women aged 50 to 75 who report being up-to-date with colorectal cancer screening from 62% to 80% (Baseline: MT BRFSS, 2016)	

Tobacco use remains the leading cause of preventable death, with 1,600 tobacco-related deaths occurring in Montana each year.

Objectives to Improve Health Equity: By 2023	HP 2020:
1. Decrease the percent of low-income adults (defined as adults whose household income would qualify for HELP, or salary range less than 138% poverty level) who currently use tobacco from 41% to 39%(Baseline: MT BRFSS, 2018)	X
2. Decrease the percentage of American Indian adults who currently use commercial tobacco from 43% to 39% (Baseline: MT BRFSS, 2016)	X
3. Decrease the percentage of American Indian youth who currently use commercial tobacco from 40% to 36% (Baseline: MT YRBS, 2017)	X
4. Decrease the percent of low-income adults (defined as adults whose household income would qualify for HELP, or salary range less than 138% poverty level) who are currently obese from 31% to 29% (Baseline: MT BRFSS, 2018)	X
5. Decrease the percentage of American Indian adults who are currently obese from 32% to 28% (Baseline: MT BRFSS, 2016)	X
6. Decrease the percent of WIC-enrolled children in Montana (ages 2-4) who are obese from 12% to 10% (Baseline: MT WIC data, 2017)	X
7. Decrease the percentage of American Indian youth who are currently obese from 20% to 15% (Baseline: MT YRBS, 2017)	X
8. Increase the percentage of Medicaid adults aged 50 to 75 who report being up to date with colorectal cancer screening from 9.9% to 10.4% (Baseline: Medicaid data, 2017)	
9. Increase the percentage of American Indian adults aged 50 to 75 who report being up to date with colorectal cancer screening from 46% to 63% (Baseline: MT BRFSS, 2016)	

Prevention and Health Promotion Strategies:

- Implement promising practices and evidence-based programs that facilitate chronic disease prevention and self-management and increase referrals to those programs (e.g. Walk with Ease, Worksite Wellness Programs, Rx Trails, Diabetes Prevention Program [DPP], Diabetes Self-Management Education and Support [DSMES] programs, Baby-Friendly Hospital Initiative, Women, Infants and Children [WIC] Breastfeeding Peer Counselor Program, Montana Tobacco Quit Line, American Indian Commercial Tobacco Quit Line).
- Implement public education campaigns to increase awareness of behaviors that address chronic disease prevention and self-management.
- Increase cancer screening using nationally recognized guidelines for breast, cervical, and colorectal cancers.

Clinical Strategies:

- Advocate for policy and workflow changes within healthcare systems to increase screening, counseling, referrals, and high quality care. Seek out involvement with Urban Indian Health Centers and tribal health departments to participate in such projects.
- Increase referrals to evidence-based chronic disease prevention and self-management programs (e.g. Montana Tobacco Quit Line, American Indian Commercial Tobacco Quit Line, Diabetes Prevention Program [DPP], Diabetes Self-Management Education and Support [DSMES], Walk With Ease, and Chronic Disease Self-Management Programs [CDSMP]).
- Provide ongoing resources and support to birth facilities and staff to become certified by the Baby-Friendly Hospital Initiative.
- Provide ongoing resources and culturally appropriate trainings to support breastfeeding among American Indian populations.
- Refer every WIC participant who is overweight/obese to a registered dietitian for nutrition education.
- Implement evidence-based interventions and supporting strategies to increase breast, cervical, and colorectal cancer screening rates in clinical health system settings.

Policy Strategies:

- Promote improvement and implementation of school wellness policies, including smoke-free and tobacco-free environments in communities and on reservations, access to nutritious food, active transportation, physical education, recreation facilities open to the community, and reduced screen time use.
- Promote and support the implementation of local community active transportation policies.
- Support creation of worksite policies that promote healthy work environments such as increasing opportunities for employees to engage in physical activity and improving access to healthy food.
- Support partners to implement Tobacco 21, include e-cigarettes in local Clean Indoor Air Act protocols, and increase the tobacco tax on all tobacco products.

Health Equity Strategies:

- Develop and disseminate culturally appropriate chronic disease prevention and self-management education materials for target populations.
- Increase access to evidence-based programs for chronic disease prevention and self-management for vulnerable populations (including telehealth to rural and frontier areas, accessibility adaptations for people with disabilities, locations on American Indian reservations, team-based care, training for healthcare professionals, and support for Medicaid members).

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Alliance for Healthy Montana
- American Association of Diabetes Educators
- American Cancer Society
- American Cancer Society Cancer Action Network
- American Diabetes Association
- American Heart Association
- Bike Walk Montana
- Billings Area Indian Health Service
- Comprehensive Primary Care Plus Clinics
- Local Health Departments
- Local Boards of Health
- Million Hearts Workgroup
- Montana Association of Counties
- Montana Diabetes Advisory Coalition
- Montana Diabetes Educators Network
- Montana Medicaid
- Montana Office of Public Instruction
- Montana Primary Care Association
- Mountain-Pacific Quality Health Foundation
- Montana Public Health Association
- Montana State University Office of Rural Health
- Montana Tobacco Prevention Specialists
- NASPA (Student Affairs Administrators in Higher Education)
- Patient-Centered Medical Homes Clinics
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- State of Montana Health Care & Benefits Division
- The Sonoran Institute
- Stroke Workgroup
- Tribal Health Departments
- University of Montana Rural Institute Disability & Health Program
- Western Transportation Institute

Priority Area 3

Motor Vehicle Crashes

This Priority Area Includes:

- Motor Vehicle Crash-Related Injury and Mortality
- High-Risk Driving Behaviors

The Problem:

Motor vehicle crashes (MVCs) are one of the most common causes of both fatal and non-fatal injuries in Montana. MVCs result in huge medical and productivity loss, especially since younger people are disproportionately affected.[15] High-risk driving behaviors, such as not wearing a seatbelt consistently, speeding, impaired driving, and distracted driving, are prevalent in Montana.[16]

From 2011–2016, 60% of all MVC related fatalities involved a driver impaired by alcohol or drugs, and among fatalities to occupants of vehicles with seatbelts available, nearly 67% were unrestrained.[17] Distracted driving is also common; 54% of high school students reported texting or emailing while driving in 2017.[7]

From 2011–2016, Montana had an unintentional motor vehicle fatality rate of 19 per 100,000 people compared to the national rate of 11 per 100,000. During this time period, the MVC mortality rate was more than three times higher among American Indians than whites.[18] Furthermore, from 2011-2015, Montana residents of rural counties (populations of less than 10,000 people) had more than double the MVC mortality rate than residents of micropolitan or small metro counties.[5]

Goal:

1. Prevent deaths and traumatic injuries due to motor vehicle crashes by mitigating the pre-crash, during crash, and post-crash factors among Montanans overall and among American Indians.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease age-adjusted mortality rate due to MVCs from 19 deaths per 100,000 people to 12 deaths per 100,000 (Baseline: MT Office of Vital Statistics, 2012-2016)	X
2. Increase the proportion of adult motor vehicle occupants that report always wearing seatbelts from 75% to 79% (Baseline: MT BRFSS, 2016)	X
3. Increase the proportion of high school students that report always wearing seatbelts while riding in a car driven by someone else from 52% to 55% (Baseline: MT YRBS, 2017)	X
4. Decrease the proportion of MVC fatalities that involve alcohol-impaired drivers from 40% to 38% (Baseline: FARS, 2012-2016)	
5. Decrease proportion of high school students who report texting or emailing while driving from 54% to 51% (Baseline: MT YRBS, 2017)	
6. Decrease age-adjusted rate of non-fatal ED visits related to MVCs from 409 per 100,000 people to 388 per 100,000 (Baseline: MHDDS, 2016)	
7. Decrease age-adjusted rate of non-fatal hospitalizations related to MVCs from 38 per 100,000 people to 36 per 100,000 (Baseline: MHDDS, 2016)	

Objectives to Improve Health Equity: By 2023	HP 2020:
1. Decrease age-adjusted mortality rate due to MVCs among American Indians from 55 per 100,000 people to 52 per 100,000 people (Baseline: MT Office of Vital Statistics, 2012-2016)	X
2. Increase the proportion of adult American Indian motor vehicle occupants that report always wearing seatbelts from 69% to 72% (Baseline: MT BRFSS, 2016)	X
3. Increase the proportion of American Indian youth less than 18 years of age that report always wearing seatbelts while riding in a car driven by someone else from 32% to 34% (Baseline: MT YRBS, 2017)	X
4. Decrease age-adjusted rate of non-fatal healthcare visits due to MVCs among American Indians from 660 per 100,000 people to 627 per 100,000 (Baseline: IHS NDW, 2017)	
5. Increase the average seatbelt use rate for vehicle occupants in the Billings Area IHS observational seat belt survey (Montana service units) from 27% to 29% (Baseline: Billings Area IHS, 2018)	

Prevention and Health Promotion Strategies:

- Promote Montana Department of Transportation's (MDT) Comprehensive Highway Safety Plan's Vision Zero: zero deaths and zero serious injuries on Montana roadways.
- Support efforts of MDT SOAR project (Safe On All Roads), which focuses on reducing American Indian traffic fatalities and serious injuries.
- Increase awareness of high-risk driving behaviors.
- Support improved surveillance of MVCs through data linkages.
- Support efforts of the MDT teen peer-to-peer traffic safety program and campaigns.

Clinical Strategies:

- Support further development of the trauma system (both EMS and trauma facilities) to reduce severity of injury outcomes.

Policy Strategies:

- Support primary seatbelt law.
- Support policies to reduce distracted driving.
- Support increasing age requirements on child passenger restraints from aged 5 years to 8 years.
- Support increasing age requirements for graduated licensing learners permits from aged 14 years to 16 years.
- Support increasing age requirements for graduated licensing unrestricted license from aged 16 years and 6 months to 18 years old.
- Encourage the use of alcohol/drug monitoring, such as the 24/7 program (which includes ignition interlocks), for DUI offenders.
- Encourage community design policies that keep all road users safe.
- Engage with tribal governments to implement proven policy interventions in their jurisdictions.

Health Equity Strategies:

- Utilize data on age groups, geographic regions, and gender to identify high-risk groups.
- Develop and implement culturally competent materials and programs to address disparities in MVC fatalities and high-risk driving behaviors.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Billings Area Indian Health Service
- City Planners
- Montana's Comprehensive Highway Safety Plan Partners
- Department of Corrections
- Department of Justice
- Department of Revenue
- Highway Patrol
- Local Health Departments
- Local Boards of Health
- Montana Association of Counties
- Montana Department of Transportation
- Montana Judicial Branch
- Montana Public Health Association
- Office of Public Instruction
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Schools
- Sheriffs
- Tribal Governments
- Tribal Health Departments

High-risk driving behaviors, such as not using a seatbelt consistently, speeding, impaired driving, and distracted driving are highly prevalent in Montana.

Priority Area 4

Healthy Mothers, Babies, and Youth

This Priority Area Includes:

- Unintended Pregnancy
- Breastfeeding
- Low Birth Weight
- Pre-Term Births

The Problem:

The well-being of mothers, infants, and children influences the health of the next generation and forecasts the future health challenges of Montana families, communities, and the health care system. Unintended pregnancy can result in adverse maternal and child health outcomes. In 2015, 32% of Montana births were unintended and of these, 7% were the result of an unwanted pregnancy.[19] Among American Indian women and young adult women (aged 18 to 24 years), one in three pregnancies are reported as intended.[19] Women with unintended pregnancies are more likely to engage in risky behaviors during pregnancy, such as smoking and drinking. Drinking alcohol while pregnant can cause Fetal Alcohol Spectrum Disorders (FASD), which can lead to intellectual and developmental disabilities for the growing child.[40]

Approximately 12,000 live births occur each year in Montana, and while the infant mortality rate remains lower than the national rate (5.7 and 6.2 deaths per 1,000 births, respectively), American Indians are disproportionately affected with a rate of 10 per 1,000 births.[20] The majority of infant deaths in Montana are sleep-related incidents.[21]

In 2015, the American Academy of Pediatrics reported the national breastfeeding initiation rate was 65% while the rates among WIC participants was 70%. Montana's WIC breastfeeding rate at 78% is higher than the national WIC rate, but lower than the Healthy People 2020 target rate of 82%.[22, 23] However, the American Indian women participating in Montana's WIC program had a much lower rate of breastfeeding initiation (63%) than white women in the same program.[22]

Each year in the United States, approximately 8% low birth weight (LBW) births (less than 2,500 grams) and 10% preterm births (PTB) (less than 37 weeks gestation) occur. LBW and PTB are associated with numerous poor birth outcomes including respiratory distress syndrome, retinopathy, jaundice, infections, and other serious conditions. LBW and PTB are associated with diabetes, heart disease, high blood pressure, developmental disabilities, and obesity later in life.[24] Montana's American Indian populations have disproportionately higher rates of PTB at 13% compared to 9% for all Montana births.[25]

Goals:

1. Decrease unintended pregnancies by increasing the use of effective contraception methods.
2. Increase home visiting services for all Montana families.
3. Increase education and awareness of the importance of prenatal care, birth outcomes, postpartum care, and childhood health.
4. Increase childhood and adolescent immunizations.
5. Decrease maternal and child health disparities among American Indian populations.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease the infant mortality rate for all Montanans from 6 per 1,000 live births to 5 per 1,000 live births (Baseline: MT Office of Vital Statistics, 2016)	X
2. Decrease the number of sleep-related infant deaths from 1.4 per 1,000 to .84 per 1,000 (Baseline: MT DPHHS FICMR Data System, 2016)	
3. Decrease the percentage of births resulting from unintended pregnancy from 23% to 22% (Baseline: PRAMS, 2017)	X
4. Decrease the percent of live births that were low birth weight (less than 2,500 grams) for all Montanans from 7.9% to 5.9% (Baseline: MT Office of Vital Statistics, 2016)	X
5. Decrease the prevalence of premature births (less than 37 weeks gestation) for all Montanans from 9% to 7% (Baseline: MT Office of Vital Statistics, 2016)	X
6. Increase the percentage of pregnant women who receive early and adequate prenatal care from 86% to 91% (Baseline: MT Office of Vital Statistics, 2016)	X
7. Increase breastfeeding initiation rates of WIC-participating infants from 78% to 82% (Baseline: MT DPHHS WIC Data System, 2017)	X
8. Increase the percentage of children aged 24–35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine from 62% to 70% (Baseline: National Immunization Survey, 2018)	X
9. Increase the percentage of adolescents aged 13–17 years who have at least one dose each of Tetanus, Diphtheria and Pertussis (Tdap), Meningococcal (MCV4), and Human Papillomavirus (HPV) from 90% (Tdap), 71% (MCV4), and 49% (HPV) to 93%, 80%, and 70% respectively (Baseline: National Immunization Survey, 2017)	
10. Increase the percentage of people immunized against influenza in all children aged 6 months to 17 years from 49% to 60%, adults aged 19 to 64 years from 34% to 60%, and adults aged 65 and older from 65% to 70% (Baseline: National Immunization Survey, BRFSS, 2017-2018)	X
11. Increase the percentage of women who are screened for postpartum depression after delivery from 91% to 96% (Baseline: PRAMS, 2017)	
12. Increase the percentage of babies in safe sleep environments from 80% to 84% (Baseline: PRAMS, 2017)	

Objectives to Improve Health Equity: By 2023	HP 2020:
1. Decrease the infant mortality rate for American Indians from 13 per 1,000 live births to 11 per 1,000 live births (Baseline: MT Office of Vital Statistics, 2016)	X
2. Decrease the percent of live births that were preterm births (less than 37 weeks gestation) for American Indians from 13% to 11% (Baseline: MT Office of Vital Statistics, 2016)	X
3. Increase the percent of pregnant women who receive early and adequate prenatal care for American Indians from 41% to 43% (Baseline: MT Office of Vital Statistics, 2016)	X
4. Increase breastfeeding initiation rates of American Indian infants from 80% to 84% (Baseline: PRAMS, 2017)	X
5. Establish a baseline measure for children aged 19–35 months enrolled in Medicaid who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine	X

Breastfeeding has numerous health benefits for both mother and infant. Montana's WIC breastfeeding rate at 78% is higher than the national WIC rate.

Prevention and Health Promotion Strategies:

- Promote the use of effective birth control methods for women not desiring pregnancy, especially for youth, low-income women, and American Indian women.
- Promote home visiting services through outreach to health clinics, local and tribal health departments, WIC, birthing hospitals, and local Child Protective Service (CPS).
- Provide Breastfeeding Peer Counseling services at local agencies and Breastfeeding Learning Collaborative training at Baby-Friendly Hospitals.
- Promote and increase the number of local and tribal health departments that provide access to public health services and education, child immunizations, and postpartum care.
- Promote and increase the number of local and tribal health departments providing education and support of safe-sleep environments.
- Increase awareness about adult vaccines, including influenza.
- Participate in HPV/Adolescent Working Group activities, including MT TeenVax.

Clinical Strategies:

- Increase the percentage of Title X Family Planning clients and Medicaid members using effective birth control methods.
- Increase the number of health systems implementing pregnancy support interventions, such as the Medicaid Promising Pregnancy Care program.
- Build new functionality into imMTrax, the state immunization registry, so clinics can review coverage levels in real time.
- Provide monthly missing immunization reports to participating providers.
- Pilot stand-alone clinic assessment (AFIX) visits for select providers.
- Health systems adopt integrated, team-based behavioral health services to screen for and treat perinatal SUD and mental illness during prenatal care.

Policy Strategies:

- Implement evidence-based teen pregnancy prevention programming in Montana public schools.
- Support integration and collaboration between Maternal and Child Health population-based programs with other DPHHS programs that support this group (e.g., asthma home visiting, tobacco cessation, chronic disease self-management, and communicable diseases prevention and treatment for Sexually Transmitted Infections, immunizations, and HIV/AIDS).
- Annually examine existing requirements for licensed childcare facilities and update as necessary to align, as feasible, with the Advisory Committee on Immunization Practices.

Health Equity Strategies:

- Develop culturally competent materials for American Indian communities.
- Promote the use of social media to reach youth populations.
- Secure funding for public health programs that serve low-income populations.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Best Beginnings
- Healthy Mothers, Healthy Babies
- Indian Health Service
- Local Health Departments
- Local Boards of Health
- Montana Association of Counties
- Montana Health Care Foundation
- Montana Medicaid
- Montana Medical Association
- Montana Office of Public Instruction
- Montana Office of Vital Statistics
- Montana Personal Responsibility and Education Program
- Montana Primary Care Association
- Montana Public Health Association
- Montana Title X Family Planning Program
- Mountain-Pacific Quality Health Foundation
- National Campaign to Prevent Teen and Unintended Pregnancy
- Office of Population Affairs
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Service Area Authorities
- Tribal Health Departments
- Urban Indian Health Centers

Priority Area 5

Adverse Childhood Experiences (ACEs)

A Cross-Cutting Issue

The Problem:

Adverse Childhood Experiences (ACEs) are traumatic events and include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, substance misuse within the household, household mental illness, parental separation or divorce, and having an incarcerated household member. The harmful effects of ACEs on health status throughout the lifespan have been well documented.[35]

Studies have shown an association between ACEs and chronic disease, behavioral health issues, and initiation of risky health behaviors. Studies have also documented a dose-response relationship between ACEs and adverse health and behavioral health outcomes, meaning that persons with more ACEs (a higher ACE score) are more likely to have more adverse health outcomes.[30]

A recent systematic review and meta-analysis of the published literature on ACEs indicated that persons with four or more ACEs were at increased risk for all negative health outcomes examined in the study. The strongest associations were found with problematic drug use, interpersonal and self-directed violence, sexual risk taking, poor mental health, and problematic alcohol use, followed by moderate associations with smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, and respiratory disease. While considered weak or modest, associations were nonetheless documented with physical inactivity, overweight or obesity, and diabetes.[31]

Since multiple ACEs can be considered a major risk factor for many health conditions, a public health approach to ACEs and childhood trauma is warranted. While clinical treatment of psychological trauma is well-established, population-based strategies for prevention are still emerging.[33]

Recognizing ACEs/trauma-informed strategies need to be applied across the health priorities addressed in this plan, the SHIP Coalition determined this special section of the plan should describe key cross-cutting strategies. Every effort should be made to support populations that are potentially disproportionately affected by this issue. In 2011, 60% of Montana adults reported having one or more ACEs. A higher percent of American Indian than white non-Hispanic adults reported experiencing four or more ACEs, as did adults who had not completed high school compared to those who had more education, adults with lower annual incomes compared to those with higher incomes, and adults with disabilities compared to those without disabilities.[32]

ACEs Strategies:

- Implement community-based strategies recommended by the Centers for Disease Control and Prevention to prevent ACEs and trauma and increase resiliency, including: providing quality and affordable child care and education early in life; strengthening economic supports for families; changing social norms to support parents and positive parenting; enhancing parenting skills to promote positive child development; and intervening to lessen harms and prevent future risk to children.[38]
- Integrate knowledge about the wide-spread effects of ACEs and trauma into policies, procedures, practices, and environments of health, human service, education, and other organizations serving children, with the goals of providing trauma-informed approaches and reducing re-traumatization. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides direction in implementing trauma-informed approaches across 10 organizational domains in its publication, "Concept of Trauma and Guidance for a Trauma-Informed Approach." Those domains are: governance and leadership, policy, physical environment, engagement and involvement, cross-sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing, and evaluation.[36]
- Implement resiliency-building and trauma informed educational and behavioral approaches in schools and early childhood settings (e.g., Montana Behavioral Initiative, social-emotional learning practices, and restorative rather than punitive disciplinary practices).
- Promote the use of early childhood home visitation programs, as recommended by the Community Preventive Services Task Force and based on strong evidence of effectiveness in reducing child maltreatment among high-risk families. Home visitation to prevent violence includes programs in which parents and children are visited in their home by nurses, social workers, paraprofessional and community peers. Visits must occur during the child's first two years of life, but they may be initiated during pregnancy and may continue after the child's second birthday.[39]
- Increase awareness of and referrals to evidence-based early childhood home visitation programs among healthcare, human service, and other professionals.
- Develop and maintain a state-level resource to share information about ACEs and trauma-informed approaches (e.g., resources for various fields of practice, training and education opportunities, support for organization moving toward trauma-informed approaches, and resources for individuals, families, and communities).

ACEs Strategies Continued:

- Continue to support training and train-the-trainer initiatives addressing ACEs and trauma-informed approaches for health and human service providers, educators, early childhood service providers, schools, communities and other organizations, including those provided by the DPHHS, ChildWise Institute, Elevate Montana, and the National Native Children's Trauma Center.
- Screen for ACEs and trauma among high-risk parents and children using age-appropriate and setting -specific screening tools, as recommended in professional guidelines for various disciplines. When results are positive, assure appropriate referrals and follow-up services.
- Promote the use of group and individual cognitive-behavioral therapy for symptomatic youth who have been exposed to traumatic events, as recommended by the Community Preventive Services Task Force based on strong evidence of effectiveness in reducing psychological harm.[39]
- Promote the use of evidence-based clinical interventions included in the Substance Abuse and Mental Health Services Administration National Registry for Evidence-Based Programs. This registry includes 14 evidence-based interventions that are targeted to specific populations and/or settings.[34]
- Implement strategies described in this plan to mitigate the health consequences of ACEs/trauma which include increased prevalence of chronic disease; increased risk for depression, mental illness, substance use disorders and suicide attempts; early initiation and continued misuse into adulthood of alcohol, tobacco and other drugs; and increased prevalence of high risk sexual behaviors.
- Continue to collect and analyze data to monitor the burden of and progress toward reducing ACEs and trauma in Montana (e.g., data regarding the prevalence of ACEs, the extent to which training and education regarding ACEs is being provided, implementation of trauma-informed approaches, and provision of home visitation services).

Studies have shown an association between ACEs and chronic diseases, behavioral health issues, and initiation of risky health behaviors.

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Appendix A: Development and Implementation of the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP)

The PHSD established the State Health Improvement Coalition in 2017. The goal of this coalition is to support DPHHS in the development, implementation, and monitoring of the 2019–2023 SHA and SHIP. The SHA describes the current population-level health status of Montanans. It includes multiple quantitative data sources (e.g., birth and death records, hospitalization data, Behavioral Risk Factor Surveillance System, and Youth Risk Behavioral Surveillance System data) that describe the health status of Montanans. In addition, the SHA also includes summarized qualitative data compiled from the 52 local community health assessments and community health improvement plans completed by local and tribal health departments and the community health needs assessments completed by hospitals across Montana. The coalition used this information to identify and prioritize the health improvement areas, goals, strategies, and objectives described in this plan. In addition to the work of the SHIP coalition, the findings from the SHA and the proposed SHIP priority areas were presented to multiple stakeholder and partner groups who provided valuable feedback on the assessment and the plan.

Appendix B: Acknowledgements

We would like to thank those groups and agencies that were involved in developing and providing feedback on the State Health Assessment and State Health Improvement Plan:

- Addictive and Mental Disorders Division, Department of Public Health and Human Services
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- Cascade City-County Health Department
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- Fallon County Health Department
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- Helena Indian Alliance
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- Lincoln County Health Department
- Montana Association of Counties
- Montana Chapter of American Academy of Pediatrics
- Montana Department of Environmental Quality
- Montana Diabetes Coalition
- Montana Environmental Health Association
- Montana Healthcare Foundation
- Montana Hospital Association
- Montana Medical Association
- Montana Pharmacy Association
- Montana Public Health Association
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How to use the State Health Improvement Plan

Top five health issues

The five issues addressed in the State Health Improvement Plan are:

- Behavioral Health
- Chronic Disease Prevention and Self-Management
- Motor Vehicle Crashes
- Healthy Mothers, Babies, and Youth
- Adverse Childhood Experiences (ACEs)

CONTACT
Anna Bradley
Plans Coordinator
(406) 444-5968
abradley@mt.gov

The 2019-2023 State Health Improvement Plan (SHIP)

The SHIP is an action-focused 5-year plan to address key health issues and improve the health and well-being of Montanans. Groups across Montana are working together to improve behavioral, maternal, and child health and reduce chronic disease and motor vehicle crashes.

The SHIP is a tool for everyone. Here are some ways it can be used:

Read the SHIP. *Access a copy of the SHIP online using the website below. Does it match what you see in your community? Is your community or organization working on these health issues? How can you team up with partners in your area to work on them?*

Get involved. *Many local and tribal health departments lead efforts to identify health issues and make plans to improve health. Be a champion for community health planning; contact your local or tribal health department to learn about their work and ask how you can participate.*

Align plans or policies. *Ask local government, businesses, schools, non-profits, and other groups to align their efforts with the key health issues in the SHIP and to include the SHIP in their planning documents and policies. It will take everyone working together to successfully improve the health of Montanans.*

Tell us how you are using the SHIP with the "A Healthier Montana" comment box at https://dphhs.mt.gov/ahealthiermontana.

RESOURCES

For more information and to download the SHIP, visit the A Healthier Montana website at https://dphhs.mt.gov/ahealthiermontana. You'll also find:

The 2017 State Health Assessment (SHA), a report about the overall health of Montanans.

Additional statewide health improvement plans, such as the Comprehensive Cancer Control Plan, the Montana Suicide Prevention Plan, and more.


MONTANA
DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Montana Substance Use Disorder Task Force Strategic Plan

Introduction

Substance use is an ongoing concern in the state of Montana, affecting individuals and families across the lifespan. This plan, the second of its kind in our state, outlines strategic actions that partners in Montana will take to collectively address the issue of substance use from a public health perspective.

More than 100 people die every year from drug overdose in Montana. and more than 15,000 emergency department visits annually are attributable to substance use.[1] The impacts of substance use span every generation and cut across socioeconomic lines, from children in our foster care system, to adults in our correctional facilities, to seniors prescribed opioids for chronic pain.

Partners across our rural state have collaborated under a shared strategic plan to develop more robust, evidence-based systems to prevent, treat, and manage substance use disorders (SUD) in Montana since 2017. With tens of thousands of individuals in our state impacted by this issue, we must continue to work collectively to implement the strategies under this updated plan to make further progress.

This plan outlines a series of targeted strategies in six key areas that Montanans can implement to lessen the impact of substance use in our state.

- Partnerships
- Surveillance and Monitoring
- Prevention
- Treatment and Recovery
- Harm Reduction
- Enforcement and Corrections

The Montana Substance Use Disorder Task Force Strategic Plan initially focused on the epidemic associated with prescription and illicit opioid use in Montana. While the current strategic plan does not focus on all areas of SUD, the Task Force continues to expand its focus more broadly on other SUD related issues (e.g. methamphetamine). The framework covered through the six focus areas described above is relevant for addressing other SUDs. If you have questions about this plan, contact the DPHHS Injury Prevention Program at their website below.

Letter from the Governor

Montanans are committed to helping individuals and families affected by opioid substance use reclaim their lives and get on a path to recovery.

An estimated 79,000 Montanans struggle with substance use disorders, the impacts of which reverberate through families and communities across our state. Drug overdoses are the fourth leading cause of injury-related death in Montana, accounting for 1,437 deaths from 2007-2018, and Montanans aged 35-54 years have the highest rate of drug poisoning deaths. Though Montana has bucked national trends with sustained declines in opioid overdose deaths in recent years, hundreds of thousands of Montanans continue to be affected by substance misuse and abuse.

At the start of our last strategic plan addressing substance use disorders in the state, the national average for opioid overdose deaths mirrored that of Montana: 5.5 deaths per 100,000 to Montana's rate of 5.4 deaths per 100,000. **Now, at the launch of the second iteration of the strategic plan, the state opioid overdose rate has fallen to 2.7 deaths per 100,000. Compared to the national opioid overdose rate of 22.8 deaths per 100,000, Montana is strategically situated to continue successfully addressing this crisis, but we understand that now is not the time to be complacent in our efforts.**

Our state's coordinated efforts to fight the substance use epidemic have helped to protect the lives of our citizens. Under the strategic taskforce and state strategic plan since 2016, we have created strong partnerships between local, tribal and state health and justice partners. We have improved our systems for helping affected individuals access treatment and sustain recovery. We have expanded surveillance and improved data collection to ensure real time monitoring of the crisis and rapid public health response. We have expanded access to drug treatment courts and evidence-based care while promoting harm reduction and appropriate justice system diversion. Between the work of the Montana Substance Use Disorders Taskforce and the recent directive to make federal opioid funding available to work in the fight of stimulants, I am confident we can continue to make progress to reduce the impact of overdoses in our great state.

I have continued to fight for Medicaid expansion, which helps to provide additional coverage for the treatment of substance use disorders. Access to care is critical, and without the expansion, some of our populations most vulnerable would be left without the resources to access affordable health coverage.

This state strategic plan, now in its second iteration, continues to be supported and adapted by the Montana Substance Use Disorders Taskforce, which is made up of more than 250 individuals representing over 135 organizations. This Taskforce is comprised of a wide variety of stakeholders, including medical professionals, law enforcement, public health and education, state agencies, and non-profit workers. Together, they continue to work toward a healthy and safe Montana.

Sincerely,

STEVE BULLOCK
Governor

Table of Contents

PARTNERING TO ADDRESS SUBSTANCE USE IN MONTANA

THIS UPDATED STRATEGIC PLAN WAS DEVELOPED WITH PARTNERS ACROSS OUR STATE.

The Montana Department of Public Health and Human Services (DPHHS) first convened the Montana Substance Use Disorders (SUD) Taskforce with funding from the Centers for Disease Control and Prevention's Data Driven Prevention Initiative in the fall of 2016. The taskforce, which meets four times per year, has engaged a total of 250 individuals representing 135 organizations statewide. In the spring of 2017, the MT SUD Taskforce published its first strategic plan for addressing substance use in our state.

Operating under this plan from 2017-2019, Montana implemented numerous strategies to improve systems for preventing, treating, and tracking SUDs statewide. Under this plan, DPHHS engaged justice system, community and health partners and developed data sharing agreements for tracking the opioid epidemic and SUDs more broadly in our state. From 2017-2019 the number of providers waivered to prescribe buprenorphine for the treatment of opioid use disorders in Montana grew from less than 20 to 150, and nearly 1,000 additional medical providers began accessing the prescription drug registry each month. In 2019, legislation was passed mandating use of the prescription drug registry, requiring identification to pick up opioid prescriptions, and limiting first time opioid prescriptions to a seven-day supply. Bucking national trends, Montana's opioid overdose death rate declined from 7.4 deaths per 100,000 in 2009-2010 to 2.7 deaths per 100,000 in 2017-2018.[1]

In the fall of 2019, Montana received three years of additional funding through a cooperative agreement with the CDC's Overdose Data to Action (OD2A) initiative to continue to implement activities to reduce overdose deaths in Montana. The focus areas for OD2A are:

- Increased timeliness and accuracy of surveillance data to improve drug overdose intervention.
- Greater awareness of opioid and other drug overdoses within the state, leading to increased preparedness and response at the local and state level.
- Decreased high-risk opioid prescribing while increasing education to those receiving opioid prescriptions (both opioid-naïve and legacy patients) and increasing access/use of non-opioid and non-pharmacologic treatments of pain.
- Improved utilization of evidence-based prevention, intervention, and referral to treatment at the local and state level.

Utilizing this funding, DPHHS worked with Taskforce partners to update the strategies for addressing substance use in our state. Through a number of participatory sessions in late 2019 and early 2020, SUD Taskforce members prioritized the strategies that are included in this updated plan. As a western state heavily impacted by methamphetamine use, we have advocated for a holistic focus for this plan which will improve the system for preventing, tracking and treating all SUDs impacting Montanans. New federal guidelines allow us to direct funds to address stimulant use as well as opioids. Working together, we will continue to reduce the negative health impacts of opioids and other drugs in our state.

Key Accomplishments

Under the first Addressing Substance Use Disorders strategic plan from 2017-2019, Montana partners made major strides to reduce the overall burden of opioid overdose in the state. Major accomplishments under the first plan include:

Partnerships

- The Montana Substance Use Disorders Taskforce engaged over 250 partners from organizations and agencies across the state
- More than $30 million of federal funding was secured by partners to address opioid use in Montana
- Montana created an epidemiologic workgroup focused on substance use disorders and analyzed justice system and prescription drug registry data that had not been previously available

Prevention and Education

- We awarded 35 mini-grants to local communities to support evidence-based prevention activities such as education for youth and drug take back events
- 100,000 Deterra bags for safe opioid disposal were distributed across all Montana counties and the number of medication drop boxes grew to 164
- 1,600 units of Naloxone, the life-saving opioid overdose reversal drug, were dispensed
- New legislation now limits first time opioid prescriptions and requires identification for opioid prescription pick up

Enforcement

- The number of active drug court participants grew 25%
- The Department of Corrections secured federal funding to develop a plan to implement Medication Assisted Treatment in its detention facilities

Monitoring

- The number of providers registered with the Montana Prescription Drug Registry (MPDR) grew from 3,898 to 4,785
- The number of monthly searches using the registry grew from 26,274 to 34,970
- Montana passed legislation mandating the use of the MPDR

Treatment

- The number of medical providers with buprenorphine waivers grew from 38 to 143, greatly expanding access to evidence-based opioid use disorder treatment
- Bolstered by Medicaid expansion funding and new federal and foundation grants, providers across the state began implementing evidence-based Integrated Behavioral Health Care and Opioid Use Disorder Treatment programs
- The number of naloxone master trainers grew from 0 to 530

Family and Community Resources

- The number of safe syringe programs in Montana quadrupled from 2 to 8
- Partners like the Montana Healthcare Foundation's Meadowlark Initiative sought to increase access to substance use treatment for pregnant women and mothers

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Substance Use in Montana

An estimated 79,000 Montanans have a substance use disorder[7]

Methamphetamine

44% of all open Child and Family Services placements have meth indicated.[3]

100% increase in meth violations from 2014-2018.[4]

35% of all drug violations are for meth.[4]

Marijuana

21% of high school students report marijuana use in the last month.[5]

53% of Montana youth perceive smoking marijuana regularly as risky.[6]

171K Estimated number of Montanans aged 12+ using marijuana in the last year.[7]

44% of all drug violations are for marijuana.[4]

Alcohol

64K Montanans aged 18+ have a current alcohol use disorder.[7]

1 in 3 high school students report alcohol use in the last month.[5]

18% of Montana adults report binge drinking in the last year.[8]

43% of all traffic fatalities in Montana are attributable to alcohol impaired driving.[9]

390 alcohol attributable deaths annually.[1]

Other Illicit drugs

31K Montanans used illicit drugs other than marijuana in the last year.[7]

570 heroin/opioid arrests in Montana in 2018, up from 4 in 2005.[4]

6% of young adults aged 18-25 report using cocaine in the last year.[7]

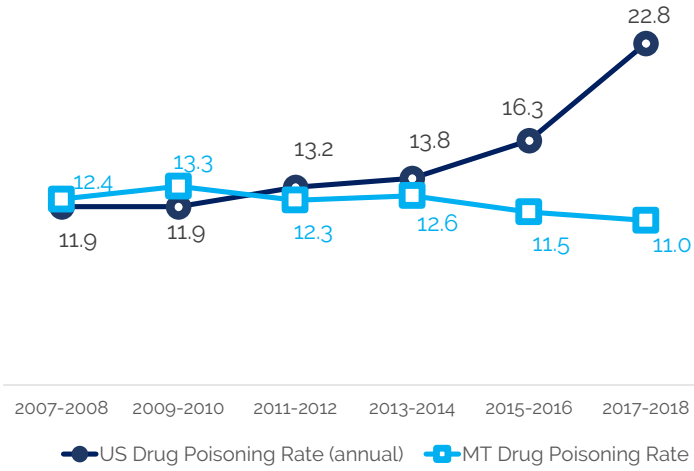
92% of Montanans with a Substance Use Disorder are not receiving treatment.[7]

Opioid Use in Montana

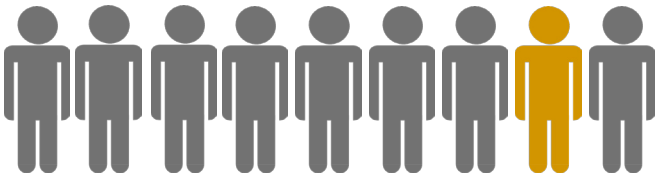
Opioid use is the primary driver of drug overdose deaths in the state of Montana. Thirty-five percent of all drug overdose deaths are attributable to opioids.[10] Montana has made progress in recent years addressing prescription opioid misuse and abuse and reducing overdose deaths, though much more can be done to ensure that opioids are prescribed, taken, and disposed of safely and that patients being transitioned off of high dose prescription opiates do not transition to illicit narcotics such as heroin and fentanyl.

Montana has 89 opioid prescriptions for every 100 residents.[11]

The drug poisoning death rate in Montana has fallen in recent years, bucking national trends.[10]



The rate of opioid overdose deaths in Montana peaked in 2008-2009 and has decreased significantly while the US rate has skyrocketed. The Montana opioid overdose rate was 2.7 per 100,000 residents in 2017-2018.[10]



One in nine high school students has misused prescription drugs.[5]

Between 2006-2018, more than 600 Montanans died from opioid overdose.[10]

Strategic Plan Overview

Overall goal

Reduce drug related morbidity and mortality across all populations in Montana

Focus Areas

- Partnerships
- Surveillance and Monitoring
- Prevention
- Treatment and Recovery
- Harm Reduction
- Enforcement and Corrections

Overall Metrics

- Decrease mortality due to all drug overdoses
  - ▼ 11 deaths per 100,000 Montanans (2017-2018)[1]
- Decrease hospitalizations due to drug overdoses
  - ▼ 920 drug cases per 100,000 admissions (2018)[2]
- Decrease emergency department visits due to drug overdoses
  - ▼ 621 drug cases per 100,000 ED visits (2018)[2]

Criteria for strategies included in this plan

- Evidence based & data driven
- Sustainable
- Realistic & achievable
- Comprehensive
- Multidisciplinary
- Trauma informed
- Empowers at-risk groups

Partnerships

Focus Area One

Metrics

- Regularly convene Substance Use Disorder Taskforce
  Target | 4 meetings per year
- Regularly convene State Epidemiologic Outcomes Workgroup
  Target | 10 meetings per year

Key Area for Action

1.1 Cross sector collaboration

Strategies & Leads

1.1.1 Support cross sector collaboration between SUD stakeholders statewide

- Montana Substance Use Disorders Taskforce **Lead |** OD2A

1.1.2 Strengthen partnerships between system leaders

- SUD Epidemiologic Outcomes Workgroup **Lead |** OD2A, OESS, AMDD
- Bi-Monthly Meetings with Opioid Grantees **Lead |** OD2A

1.1.3 Foster relationships between health and justice system partners

- Comprehensive Opioid Abuse Program (COAP) Grant **Lead |** Montana Department of Corrections (DOC)
- Engage probation and parole, Montana Board of Crime Control in the SUD Taskforce **Lead |** OD2A
- Develop relationships with juvenile justice system partners **Lead |** OD2A

Key Area for Action

1.2 Engage diverse partners

Strategies & Leads

1.2.1 Coordinate with local and tribal efforts to address SUDs

- **Leads |** Local behavioral health and prevention coalitions, local and tribal health departments, Montana Tribal Leaders, Chamber of Commerce, MSU Extension Grant, Montana Association of Counties, OD2A Mini-Grants

1.2.2 Learn from individuals with lived experience

- At least one panel per year at the SUD Taskforce **Lead |** OD2A

1.2.3 Better support children and young families affected by SUDs

- **Leads |** DPHHS Early Childhood and Family Support Division (ECFSD) , Healthy Mothers Healthy Babies (HMHB), Medicaid, Montana Head Start Association (MTHSA) and DPHHS Head Start Collaboration Office

Surveillance and Monitoring

Focus Area Two

Metrics

Decrease rate of opioid prescriptions

Baseline | 89 opioid prescriptions (excluding buprenorphine) per 100 Montanans (2017)[11]

Baseline | Mean daily MME: 49.7 (2017)[11]

Increase number of datasets analyzed

Baseline | 14 datasets (2019)

Key Area for Action

2.1 Data sharing

Strategies & Leads

2.1.1 Establish data sharing agreements with internal and external partners

- **Lead |** OD2A

2.1.2 Maintain and strengthen existing data sharing

- Continue agreements with DOC/Local Law Enforcement and Detention Facilities, PDMP, Medicaid, Rocky Mountain Tribal Leaders Council Epidemiology Center and others. **Lead |** OD2A

2.1.3 Support effective data collection and evaluation for local SUD projects

- **Leads |** OD2A, SUD Epidemiological Workgroup, HMHB Child Health Data Partnerships, Safe Syringe Programs, Community Health Assessments

Key Area for Action

2.2 Analysis and Communication

Strategies & Leads

2.2.1 Analyze datasets

- BRFSS, YRBS, and PNA
- State Unintentional Overdose Reporting System (SUDORS)
- Montana Prescription Drug Registry
- Vital statistics, Hospital Discharge, Emergency Department visits
- Naloxone use tracking—ImageTrend and Law Enforcement

2.2.2 Publish surveillance reports on substance use trends regularly

- Technical report and reports designed for consumption by the general public **Lead |** OD2A

Key Area for Action

2.3 Monitoring

Strategies & Leads

2.3.1 Transition to a new Prescription Drug Registry (PDR) platform

- Create advisory board to vet vendors, review potential systems, and guide transition to new registry and select platform with increased functionality and enhanced data fields **Lead |** Board of Pharmacy

2.3.2 Regularly share de-identified PDR data with DPHHS **Lead |** Board of Pharmacy

2.3.3 Support robust utilization of the MPDR to improve prescribing practices

- Provide education and training to providers about the new PDR functionality and how to utilize it to track and improve care **Leads |** OD2A, Department of Justice, Montana Medical Association, Montana Hospital Association, Montana Pharmacy Association
- Support implementation and education on new Montana legislation mandating MPDR use and restricting length of first opioid prescription starting in 2021 **Leads |** OD2A, Department of Justice, Montana Medical Association, Montana Hospital Association, Montana Pharmacy Association
- Support integration of the new MPDR into EHRs and pharmacy operating systems **Leads |** Board of Pharmacy, OD2A

2.3.4 Expand use of Academic Detailing to monitor morphine milligram equivalents

- **Leads |** Medicaid, Mountain Pacific Quality Health, Veteran's Administration

Prevention

Focus Area Three

Metrics

Decrease youth substance use[5]

Baseline, for Montana high school students |

- Lifetime pain prescription misuse: 12.8% (2019)
- Alcohol use, past 30 days: 33% (2019)
- Marijuana use, past 30 days: 21% (2019)
- Electronic vapor product use, past 30 days: 30% (2019)

Key Area for Action

3.1 Local prevention infrastructure

Strategies & Leads

3.1.1 Increase capacity and training opportunities for Local Prevention Specialists

- Support the certification of prevention specialists **Lead |** AMDD, OD2A and Youth Connections

3.1.2 Support local prevention coalitions to implement evidence-based programs

- Communities that Care **Lead |** Montana Healthcare Foundation, AMDD
- Drug Free Communities Grants **Lead |** AMDD
- Substance Abuse Block Grant **Lead |** AMDD
- Partnership for Success Grant **Lead |** AMDD
- Mini-grants to support local coalition work **Lead |** OD2A
- Train rural communities on opioid misuse education and safe disposal **Lead |** MSU Extension

3.1.3 Enhance capacity of tribal communities to design and implement culturally appropriate prevention activities

- **Leads |** Indian Health Service, Tribal Health Departments, Medicaid Tribal Health Improvement Program, Tribal Opioid Response Grants, and Strategic Planning, OD2A Mini-grants-OD2A

Key Area for Action

3.2 Awareness and stigma reduction

Strategies & Leads

3.2.1 Educate on opioid prescription storage and disposal

- Increase drop boxes and maintain prescription drop boxes map **Leads |** Department of Justice, local law enforcment agencies, AMDD
- Law enforcement drug take back events **Leads |** DEA and local law enforcement, Department of Justice
- Education for older adults **Lead |** AMDD

3.2.2 Educate providers on evidence-based prescribing practices

- Trainings using telehealth or online platforms
  - Know Your Dose **Lead |** Montana Medical Association
  - Mini-grants **Lead |** OD2A
  - Opioid Use Disorder Project Echo **Lead |** Billings Clinic
- In-person trainings
  - Buprenorphine waiver trainings **Lead |** Montana Primary Care Association
  - Montana Pain Conference **Lead |** Western Montana Area Health Education Center
  - Opioid Misuse in Rural Montana **Lead |** MSU Extension

3.2.3 Educate communities and promote stigma reduction initiatives

- Parenting Montana Website **Lead |** AMDD. MSU Bozeman
- Stigma and Education Campaign **Lead |** OD2A, HMHB, Open Aid Alliance
- Initiative to reduce stigma for seeking treatment for pregnant women and mothers **Lead |** HMHB
- Aid Montana **Lead |** Department of Justice
- OD2A Mini-grants **Lead |** OD2A
- Meadowlark Initiative **Lead |** Montana Healthcare Foundation, local health organizations

Key Area for Action

3.3 Adverse Childhood Experiences (ACEs) and Resiliency

Strategies & Leads

3.3.1 Provide training on ACEs, trauma informed practices, and resiliency

- Increase the number of ACE Master Trainers and ACE trainings **Lead |** Elevate Montana
- Train the trainer model for trauma-informed criminal justice responses **Lead |** SAMHSA GAINS Center
- Trauma informed care training for tribal providers **Lead |** Billings Area IHS, Mountain Pacific Quality Health
- Train early chilhood educators and medical providers **Lead |** DPHHS ECFSD, MTHSA

3.3.2 Implement mental health consultation services in early childhood settings

- Support for increased funding and training on the model **Lead |** DPHHS ECFSD

3.3.3 Develop a train-the-trainer model for 0-3 Infant-toddler mental health for Montana behavioral health professionals

- **Lead |** DPHHS ECFSD

3.3.4 Expand bi-directional referral networks for children and families experiencing trauma and behavioral health concerns

- Support use of the CONNECT referral system in early childhood settings **Lead |** OD2A
- Expand referral networks and partnerships to increase access to SUD treatment for pregnant mothers and engage medical providers in identifying where outreach/education support is needed **Lead |** Montana Healthcare Foundation, HMHB

3.3.5 Support the work of local coalitions focused on early childhood and ACEs

- **Lead |** Early Childhood Coalitions, Headwaters Zero to Five Initiative, OD2A

3.3.6 Implement prevention initiatives in schools and early childhood settings

- PAX Good Behavior Game **Lead |** Office of Public Instruction and AMDD

3.3.7 Develop curriculum for working with young children affected by SUDs

- **Lead |** Montana Head Start Association, Montana University System

3.3.8 Implement "Handle with Care" program statewide to support trauma impacted youth **Lead |** DPHHS ECFSD, ChildWise, law enforcement, and other partners

3.3.9 Support advocacy efforts on behalf of at-risk young children and families.

- **Lead |** HMHB, Early Childhood Coalitions, MTHSA

Treatment and Recovery

Focus Area Four

Metrics

- Increase annual adult and youth client admissions to state-approved substance use treatment providers
  Baseline | 8,133 (2019)[12]
- Increase providers with a waiver to prescribe buprenorphine
  Baseline | 155 (February, 2020)[13]
- Increase patients treated for SUD at community health centers
  Baseline | 1,819 (2018)[14]
- Increase buprenorphine-waivered providers at HRSA health centers
  Baseline | 48 (2018)[14]
- Increase patients receiving MAT through HRSA health centers
  Baseline | 187 (2018)[14]

Key Area for Action

4.1 Linkage to care

Strategies & Leads

4.1.1 Expand the CONNECT Referral System to treatment and recovery systems

- Fund additional local CONNECT coordinators **Lead |** DPHHS and OD2A

4.1.2 Increase the use of 211 for self-referral

- **Lead |** Local United Way affiliates, Local Advisory Councils

4.1.3 Engage colleges and universities to increase SUD-related referrals for students

- Provide localized trainings and technical assistance **Lead |** OD2A, Montana University System

Key Area for Action

4.2 Access to treatment

Strategies & Leads

4.2.1 Advocate for robust insurance coverage

- Encourage private payers and Medicaid to cover the full continuum of care and alternative pain treatments **Lead |** Montana Hospital Association, Patient advocacy groups

4.2.2 Support workforce development to enhance provider coverage statewide

- Reduce barriers to LAC credentialing **Lead |** MPCA Behavioral Health Licensing Discussion Group
- Support dual licensed and waivered providers, especially in rural communities **Lead |** Universities, AMDD, MPCA

4.2.3 Increase the use of universal assessments for SUDs

- S-BIRT **Lead |** Montana Healthcare Foundation

4.2.4 Bolster the number of providers offering Integrated Behavioral Health services

- **Lead |** MTHCF, MPCA, Behavioral Health Alliance of Montana

4.2.5 Increase access to evidenced-based care including Medication for Addiction Treatment (MAT)

- Linkages to addiction service utilizing technology as needed **Lead |** SOR Grant
- Increase number of MAT-waivered providers **Lead |** SOR Grant, AMDD, MPCA
- Implement Targeted Capacity Expansion Grant **Lead |** MAT-PDOA
- Education on MAT and other evidence-based practices **Lead |** MPCA

4.2.6 Increase the number of full service Opioid Treatment Programs

- Support the Montana Chemical Dependency Center to offer all forms of MAT **Lead |** AMDD
- Expand access to methadone through OTPs across Montana **Lead |** AMDD, local providers

4.2.7 Expand access to family centered and culturally appropriate treatment

- Support initiatives targeting pregnant women and parents **Lead |** Meadowlark Initiative, local providers
- Support implementation of the Safe Harbor Policy for pregnant women seeking treatment **Lead |** DOJ
- Provide training on perinatal mood disorders and additional post-partum mental health care resources **Lead |** HMHB
- Champion culturally appropriate care **Leads |** Urban Indian Clinics, IHS, Tribal Health Departments
- Support provision of behavioral health services according to the Culturally and Linguistically Appropriate Services standards. **Lead |** AMDD

Key Area for Action

4.3 Access to recovery and support services

Strategies & Leads

4.3.1 Foster access to recovery support groups in all communities

- **Lead |** Narcotics Anonymous and Alcoholics Anonymous, local recovery groups, faith communities

4.3.2 Increase access to and training for certified peer support specialists

- **Lead |** Montana's Peer Network, Rocky Mountain Tribal Leaders Council, AMDD, NAMI

4.3.3 Support development of Addiction Recovery Teams in local communities

- **Lead |** AMDD in partnership with local providers

4.3.4 Increase funding and support for effective case management and recovery management strategies for individuals in treatment and recovery

- **Lead |** DPHHS, private payers, Medicaid

4.3.5 Expand access to safe, affordable Recovery Housing

- **Lead |** AMDD

4.3.6 Increase access to low cost community events that are drug and alcohol free

- **Leads |** Local recovery groups, city councils and governments, Early Childhood Coalitions

Harm Reduction

Focus Area Five

Metrics

- Increase number of safe syringe programs
  Baseline | 8 (2019)[15]
- Increase the number of naloxone units distributed annually
  Baseline | 1,283 (2018)[16]
- Increase the number of naloxone master trainers
  Baseline | 538 (September 2019)[16]

Key Area for Action

5.1 Naloxone

Strategies & Leads

5.1.1 Provide online and in-person naloxone training statewide

- Target EMS, fire, law enforcement, school nurses, libraries, homeless shelters, and individuals who use or associate with people using opioids **Lead |** SOR grant, DPHHS EMS and Trauma Program, AMDD

5.1.2 Establish a master naloxone trainer in every Montana county

- **Lead |** SOR grant, EMS and Trauma, AMDD

5.1.3 Place naloxone in Automated External Defibulater kits and provide training

- **Lead |** DPHHS EMS and Trauma Systems

5.1.4 Encourage co-prescribing of naloxone with opioids

- **Lead |** MMA, Medicaid, Mountain Pacific Quality Health, Montana Primary Care Association

5.1.5 Encourage initiation of MAT in patients who receive naloxone

- **Lead |** MMA, Medicaid, Mountain Pacific Quality Health

5.1.6 Encourage naloxone distribution by pharmacies utilizing the state standing order

- **Lead |** MMA, Medicaid, Mountain Pacific Quality Health

5.1.7 Develop systems to better track naloxone use, especially for law enforcement

- **Lead |** OD2A

Key Area for Action

5.2 Safe syringe programs

Strategies & Leads

5.2.1 Support and raise awareness about existing safe syringe programs
- **Lead |** DPHHS HIV/STD Section, OD2A Mini-grants

5.2.2 Advocate for additional safe syringe programs and funding in Montana
- **Lead |** DPHHS HIV/STD Section, existing local programs

5.2.3 Utilize safe syringe programs for distribution of naloxone and linkages to care
- **Lead |** AMDD SOR Grant

5.2.4 Increase HIV and Hepatitis C testing and treatment for injection drug users
- **Lead |** DPHHS HIV/STD Section

5.2.5 Support paraphernalia amendment legislation
- Focus on benefits of increasing needle disposal and protecting public health **Lead |** Open Aid Alliance

Key Area for Action

5.3 No or low barrier housing

Strategies & Leads

5.3.1 Support the development of low barrier shelters for individuals with SUDs
- **Lead |** Montana Continuum of Care Coalition

5.3.2 • Support local Coordinated Entry system for linkage to housing resources
- **Lead |** HUD, Montana Continuum of Care Coalition

5.3.3 Develop Housing First programs to house individuals with SUD
- **Lead |** Montana Healthcare Foundation, local housing grantees and partners

5.3.4 Advocate for a Medicaid benefit for permanent supportive housing
- **Lead |** Montana Healthcare Foundation

Enforcement and Corrections

Focus Area Six

Metrics

- Increase number of treatment courts statewide
  Baseline | 37; 8 are tribal (2017)[17]
- Reduce relative risk of overdose mortality for Montanans recently released from a DOC facility
  Baseline | 27x more likely than average Montanan to die from overdose (2019)[18]
- Increase number of justice system facilities that offer MAT
  Baseline | Obtain from jail survey

Key Area for Action

6.1 Reduce supply

Strategies & Leads

- 6.1.1 Support local Drug Taskforces
  - **Lead |** Federal High Intensity Drug Taskforce Area funding, DOJ Division of Criminal Investigation
- 6.1.2 Enhance use and reach of Criminal Interdiction Teams
  - **Lead |** Montana DOJ
- 6.1.3 Train and employ additional Drug Recognition Experts
  - **Lead |** Montana Highway Patrol, local law enforcement agencies
- 6.1.4 Support the work of the Pill Diversion Agents
  - **Lead |** DOJ Division of Criminal Investigation

Key Area for Action

6.2 Crisis response and diversion

Strategies & Leads

6.2.1 Support communities to better understand and design their behavioral health crisis services through Sequential Intercept Mapping and other planning efforts

- **Lead |** Montana Healthcare Foundation, County Crisis Grants through AMDD

6.2.2 Support development of systems that appropriately divert individuals with SUD away from the justice system and into treatment

- Community agreements between law enforcement, SUD providers, and crisis response
- Mobile crisis response teams
- Co-responder models
- Clinically managed withdrawal management
- Short term crisis stabilization facilities
- Crisis Intervention Training and Mental Health First Aid training for Law Enforcement and first responders
- Empath Units
- System navigation and follow-up using peer support specialists and case managers
- **Leads |** County Matching and Mobile Crisis Grants through AMDD, Montana Healthcare Foundation, Local Advisory Councils, and other community coalitions

6.2.3 Advocate for more robust crisis funding in Montana

- Enhance federal, state, and local funding sources
- **Lead |** Montana Healthcare Foundation, County Crisis Grants through AMDD

Key Area for Action

6.3 Treatment Courts

Strategies & Leads

6.3.1 Increase access to and diversity of courts statewide, including robust family treatment court models

- **Lead |** Montana Judicial Branch

6.3.2 Increase state and federal funding for drug treatment courts

- **Lead |** Department of Justice, Montana Judicial Branch, Montana Healthcare Foundation

Key Area for Action

6.4 Access to treatment in the justice system

Strategies & Leads

6.4.1 Develop a strategic plan for increasing access to treatment in detention facilities and prisons

- **Lead |** Montana Department of Corrections COAP Grant

6.4.2 Increase access to evidence-based SUD evaluations and treatment in jails and correctional facilities

- **Lead |** COAP and Residential Substance Abuse Treatment (RSAT) grants, local providers

6.4.3 Increase access to SUD assessment and treatment in community corrections

- Improve continuity of care for individuals released into the community from DOC facilities
- **Lead |** DOC, Probation and Parole, Medicaid

6.4.4 Increase collaboration, support, and funding between juvenile probation and adult probation and parole

- **Lead |** DOC. local law enforcement agencies

6.4.5 Increase access to recovery supports for individuals who are justice system involved

- **Lead |** COAP grant

6.4.6 Distribute naloxone to individuals with SUDs upon release from jail/prison

- **Lead |** SOR Grant and DOC

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18. Montana Department of Public Health and Human Services and Montana Department of Corrections, Internal Data, 2019.

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References for Metrics

Page 10 || Substance Use in Montana

Montana Child and Family Services administrative data, 2018.

- 44% of all open Child and Family Services placements have meth indicated

Montana Statistical Analysis Center, Department of Corrections Crime Control Bureau. 2018 Crime in Montana Summary.

- 100% increase in meth violations from 2014-2018
- 35% of all drug violations are for meth
- 44% of all drug violations are for marijuana
- 570 heroin/opioid arrests in 2018, up from 4 in 2005

Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019.

- 21% of high school students report marijuana use in the last month

Montana Department of Public Health and Human Services, Prevention Needs Assessment. 2018.

- 53% of Montana youth perceive smoking marijuana once or twice a week as harmful to themselves (physically or in other ways)

SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

- An estimated 79,000 Montanans age 12+ have a substance use disorder
- 64,000 Montanans aged 18+ have a current alcohol use disorder
- 171,000 Montanans aged 12+ were estimated to have used marijuana in the last year
- 31,000 Montanans were estimated to use illicit drugs other than marijuana in the last month
- 6% of young adults aged 18-25 report using cocaine in the last year
- 92% of Montanans with a substance use disorder are not receiving treatment

Montana Department of Public Health and Human Services (MT DPHHS) and Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Helena, MT: Montana Department of Public Health and Human Services, Public Health and Safety Division, 2018.

- 18% of Montana adults report binge drinking in the last year

National Highway Traffic Administration. (2019). 2018 Fatal motor vehicle crashes: Overview.

- 43% of all traffic fatalities in Montana are attributable to alcohol-impaired driving

Page 11 || Opioid Use in Montana

Montana Department of Public Health and Human Services Injury Prevention Program, Drug Poisoning Deaths in Montana, 2007-2018.

- 35% of all overdose deaths are attributable to opioids
- The drug poisoning rate in Montana has fallen since 2010, bucking national trends
- The Montana opioid poisoning rate was 2.7 per 100,000 residents in 2017-2018

Montana Department of Public Health and Human Services Injury Prevention Program, Opioid Prescribing Practices in Montana, 2012-2017.

- Montana has 89 opioid prescriptions for every 100 residents

Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019.

- Over one in ten high school students has taken a prescription drug without a doctor's prescription

Montana Department of Public Health and Human Services, Montana Vital Statistics Analysis Unit, 2007-2018.

- Between 2006-2018, more than 600 Montanans have died from opioid overdose

Page 15 || Surveillance and Monitoring

Montana Department of Public Health and Human Services Injury Prevention Program, Opioid Prescribing Practices in Montana, 2012-2017.

- 89 opioids (excluding buprenorphine) per 100 Montanans
- 49.7 Mean daily MME

Page 17 || Prevention

Montana Office of Public Instruction, Youth Risk Behavior Survey, 2019. .

- Youth lifetime pain prescription misuse: 12.8%
- Youth alcohol use, past 30 days: 33.4%
- Youth marijuana use, past 30 days: 21.1%
- Youth electronic vapor product use, past 30 days: 30.2%

Page 20 || Treatment and Recovery

Montana Medicaid and Substance Abuse Management Information System (SAMS), 2019

- 8,133 adult and youth client admissions annually to state-approved substance use treatment providers

SAMHSA, Center for Behavioral Health Statistics and Quality, Buprenorphine Practitioner Locator, 2020.

- 155 providers with an x-waiver for buprenorphine

HRSA, Health Center Program, Montana Data, 2018.

- 1,819 patients treated for SUD at HRSA health centers
- 48 buprenorphine-waivered providers at HRSA centers
- 187 patients receiving Medication-Assisted Treatment through HRSA health centers

Page 23 || Harm Reduction

Montana Department of Public Health and Human Services STD/HIV Program, Get Tested Montana!, 2019.

- 8 safe syringe programs

Montana Department of Public Health and Human Services Addictive and Mental Disorders Division, Internal Data, 2019

- 1,283 naloxone units distributed annually
- 538 Naloxone master trainers

Page 25 || Enforcement and Corrections

Montana Supreme Court Office of Court Administrator, Montana Drug Courts: An Updated Snapshot of Success and Hope, 2019.

- 37 treatment courts statewide; 8 are tribal

Montana Department of Public Health and Human Services and Montana Department of Corrections, Internal Data, 2019

- Montanans recently released from a DOC facility are 27x more likely to die from an overdose than the average Montanan

Acronyms

AI/AN	American Indian/Alaska Native
AMDD	Addictive and Mental Disorders Division (DPHHS)
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
COAP	Comprehensive Opioid Abuse Site grant
DCI	Division of Criminal Investigation (DOJ)
DEA	Drug Enforcement Administration
DOJ	Montana Department of Justice
DDPI	Data-Driven Prevention Initiative
DOC	Montana Department of Corrections
DPHHS	Montana Department of Public Health and Human Services
ECFSD	Early Childhood and Family Services Division (DPHHS)
DPHHS	Department of Public Health and Human Services
EMS	Emergency Medical Services
HMHB	Healthy Mothers Healthy Babies
IHS	Indian Health Service
LAC	Licensed Addiction Counselor
MAT	Medication for Addiction Treatment
MCDC	Montana Chemical Dependency Center (DPHHS)
MMA	Montana Medical Association
MPCA	Montana Primary Care Association
MPDR	Montana Prescription Drug Registry
MTHCF	Montana Healthcare Foundation
OD2A	Overdose to Action Grant
OTP	Opioid Treatment Program
PDMP	Prescription Drug Monitoring Program
PDR	Prescription Drug Registry
PNA	Prevention Needs Assessment
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SOR	State Opioid Response Grant
SUD	Substance Use Disorder
YRBS	Youth Risk Behavior Survey

MONTANA SUBSTANCE USE STRATEGIC TASK FORCE

Addressing Substance Use Disorders in Montana | 2020

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MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

AMDD Community-Based Prevention Logic Model-BLOCK GRANT

Community: ***(BG) Carbon***						**Person Responsible:**	
Youth 30-Day Alcohol, Youth 30-Day Marijuana, Adult 30-Day Binge Drinking							
	Problem	**Factors**	**Focus Population**	**At-Risk Category**	**Selected Strategies**	**Short**	**Long**
Youth	(BG) 30-Day Alcohol Use Among Youth in Grades 8, 10,12	RF Perceived Risk of Drug Use (Peer and Individual Domain)	Universal- Indirect General Population of County: 10,062 people Universal -Direct- Carbon County Students in Grades K-3, 456 People		*Dissemination of Information* *Prevention Education*	Increase the number of students (8,10,12 combined) responding "Slight, Moderate, or Great Risk" to the Question: How much do you think people risk harming themselves if they take one or two drinks of an alcoholic beverage every day from 84.6% in 2018 to 87.6% in 2022. (2018 Carbon PNA Crosstab, page 17)	Reduce 30-Day Alcohol Use in grades 8,10, and 12 combined from 31.7% in 2018 to 25% in 2026. (2018 Carbon County PNA Crosstab, Page 24)
Youth	(BG) 30-Day Alcohol Use Among Youth in Grades 8, 10,12	RF Parental Attitudes Favorable to Drug Use (Family Domain)	Universal- Direct - Carbon County High School Students 822 people Universal- Direct- Carbon County Coalition Members (50 people)		*Environmental Approach* *Community -Based Process*	Increase the number of students (8,10,12 combined) responding "Very Wrong" to the Question: How wrong do your parents feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day from 60.8% in 2018 to 64% in 2022. (2018 Carbon PNA Crosstab, page 7)	Reduce 30-Day Alcohol Use in grades 8,10, and 12 combined from 31.7% in 2018 to 25% in 2026. (2018 Carbon County PNA Crosstab, Page 24)
Youth	(BG) 30-Day Marijuana Use Among Youth in Grades 8, 10, 12	RF Intention to Use Drugs (Peer and Individual Domain)	Universal- Indirect - General Population of County: 10,062 people Selective- Percentage of High School youth using marijuana (PNA Data) 182 students	Already Using Substances	*Dissemination of Information,* *Problem Identification and Referral*	Decrease the number of students (8,10,12 combined) responding 'yes" or "YES!" to the question: When I am an adult, I will smoke marijuana from 15.4% in 2018 to 13% in 2022. (2018 Carbon PNA Crosstab, page 16)	Reduce 30-Day Marijuana Use in grades 8,10, and 12 combined from 22.1% in 2018 to 15%in 2026 (2018 Carbon County PNA Crosstab, Page 24)
Youth	(BG) 30-Day Marijuana Use Among Youth in Grades 8, 10, 12	PF Rewards for Prosocial Involvement (Community Domain)	Universal-Direct- Carbon County Students in Grades K-3, 456 People Universal-Direct- Mentoring All Carbon County Students 1,294 People		*Prevention Education* *Alternative Activities*	Increase the number of students (8,10,12 combined) responding "yes" and "YES!" to the question: There are people in my neighborhood who are proud of me when I do something well from 41.6% in 2018 to 45% in 2022. (2018 Carbon PNA Crosstab, Page 4)	Reduce 30-Day Marijuana Use in grades 8,10, and 12 combined from 22.1% in 2018 to 15%in 2026 (2018 Carbon County PNA Crosstab, Page 24)

Adult	(BG) 30-Day Binge Drinking in Adults Ages 18-65+	RF Parental Attitudes Favorable to Antisocial Behavior (Family Domain)	Universal-Direct - Carbon County Adults Aged 21-65 (6,400 people) Universal-Indirect - General Population 10,062 Universal-Indirect - General Population 10,062		*Prevention Education,* *Dissemination of Information,* *Community Based Process*	Increase the number of students (8,10,12 combined) responding "Very Wrong" to the Question: How wrong do your parents feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day from 60.8% in 2018 to 64% in 2022. (2018 Carbon PNA Crosstab, page 7)	Reduce 30-Day Binge Drinking among adults ages 21-65 from 18.9% in 2016 to 11.9% in 2024 (Baseline 2016 Montana BRFSS)
Measures and Sources	2018 Montana Prevention Needs Assessment Carbon County Crosstab Report 2016 MT BRFSS	2018 Montana Prevention Needs Assessment Carbon County Crosstab Report	2018 Carbon County Census Data/ School Enrollment Data		*CSAP Strategies* *1. Dissemination of Information* *2. Prevention Education* *3. Alternative Activities* *4. Community Based Process* *5. Environmental Approach* *6. Problem Identification and Referral*	2018 Carbon County PNA Crosstab Report	2018 Carbon County PNA Crosstab Report
Evidence Based	*Provide rationale for program being evidence-based, promising, or cultural**	*Cultural practices need to be transposed into an acceptable format such as the model by Caroline Cruz					

Community: ***(BG) Carbon***

Long Term Goal:	(BG) 30-Day Alcohol Use Among Youth in Grades 8, 10,12
	(BG) 30-Day Marijuana Use Among Youth in Grades 8,10,12
	(BG) 30-Day Binge Drinking in Adults ages 18-65+
Short Term Goals:	RF Perceived Risk of Drug Use (Peer and Individual Domain)
	RF Parental Attitudes Favorable to Drug Use (Family Domain)
	RF Intention to Use Drugs (Peer and Individual Domain)
	PF Rewards for Prosocial Involvement (Community Domain)
	RF Parental Attitudes Favorable to Antisocial Behavior (Family Domain)

Action Plan

		Community Engagement Process						Funding
Activity by CSAP Strategy	**Description/ Evidence-Based Policy, Program, or Practice (See Approved List)**	**When**	**How**	**Who**	**Responsible Party**	**Resources Needed/ Training**	**Who Should Know**	**Will BG or PFS money be expended for this strategy?**
Dissemination of Information								
DOI Engaging Parents Toolkit (Parenting Montana)-Indirect	Deliver/Educate/Hand out media materials to Community Health Partners, Schools, and Public (P1, P2, P3)	March 2019-March 2020	In-person/ partnerships	PS/Public Health/Schools	PS	MSU Webex	All Community Partners/ General Public	Yes BG
Prevention Education								
PE/EB Education Programs for Youth Groups	Continue to collaborate with Fromberg and Joliet Schools to implement PAX:GBG and recruit one more school to implement PAX:GBG (P1, P2, P3)	April 2019-May 2020	In-person meeting/emails/school partnerships	PS/Clark Beggar/Riverstone Health	PS/ Riverstone	PAX:GBG Evaluation Data	Principals/ Teachers/PS	Yes BG
PE/EB Education Programs for Youth Groups	Educate and recruit 1 middle school to implement LifeSkills or Project Northland (P1,P3)	June 2019-June 2020	In-person meeting/emails/	PS/Schools	PS	EBP List, information and Costs	PS/ Schools	Yes BG
Alternative Activities								
AA Mentoring Programs	mentorship and implement a school mentoring program	May 2019-Sept 2020	meeting/emails	PS/School MBI	PS/ MBI Leaders	MBI/ Mentor Training	PS/ Schools	No BG
AA Youth and Adult Leadership Activities	engage in youth community leadership activities for	May 2019-Sept 2020	collaboration/organ	Coalition/Rotary/Lion	Leaders	Organizing Gaps/ Resources	Members	No BG
Community Based Process								
CBP Community Mobilization	Council, and DUI Task Force to collaborate on Prevention	March 2019-Sept 2020	Collaboration	Forces/MHAC/LE	PS	Coalition Building	Members	No BG
CBP Technical Assistance to Coalition Members	and Law Enforcement on Prevention Education and	March 2019- Sept 2020	Collaboration	Forces/MHAC/LE	PS	Community Resources/Gaps	Members	No BG
Environmental Approach								
EA Party Patrols	Educate Local Law Enforcement on the need to conduct saturated strategic patrols around prom and graduation times for underage drinking parties (P1)	March 2019-Sept 2020	In-person LE Education/Coalition Support	LE/Schools/County Atty/PS	PS/LE	Environmental Education/ LE Training	LE/ PS/ General Public	No BG
Problem Ident & Referral								
PIR Student Assistance Programs	Recruit one school in Carbon County to train and certify school counselors in the Screening-Brief Intervention and Referral to Treatment (SBIRT) evaluation program (P2)	March 2019-Sept 2020	In-person meetings/School and Community Partnerships	PS/School Admin and Counselors	PS/ Schools	SBIRT Training and Certification	PS/ Schools	Yes BG

AMDD Community-Based Prevention Logic Model

Community: ***(PFS) Hill***

Priority:

	Problem	**Factors**	**Focus Population**	**At-Risk Category**
	(PFS) 30-Day Alcohol Use Among Youth 9 to 20 YO	RF Perceived Risk of Drug Use (Peer and Individual Domain)	Universal Indirect: Genereral Pop 16,500. Universal Direct: Non-reservation schools: 1,000	
	(PFS) 30-Day Alcohol Use Among Youth 9 to 20 YO	RF Parental Attitudes Favorable to Drug Use (Family Domain)	Universal Indirect: General Pop: 16,500 Universal Direct: Parent-Age Adults: 3,000	
	(PFS) 30-Day Alcohol Use Among Youth 9 to 20 YO	RF Number of Students with Ten or More Risk Factors	Indicated: Estimated 350 (70% of HS)	Children of Substance Users

	(PFS) 30-Day Marijuana Use Among Youth 9 to 20 YO	PF Opportunities for Prosocial Involvement (Community Domain)	Universal Indirect: Gen Pop: 16,500. Student Pop 1,000	
	(BG) 30-Day Marijuana Use Among Youth in Grades 8, 10, 12	RF Intention to Use Drugs (Peer and Individual Domain)	Selective: Youth intention to use. HS students 350	Already Using Substances
	(PFS) 30-Day Methamphetamine Use Among Youth 9-20 y/o	RF Intention to Use Drugs (Peer and Individual Domain)	Selective: Youth At Risk HS students 200	Mental Health Problems
Measures and Sources	2018 Montana Prevention Needs Assessment XXX County Crosstabs Report	2018 Montana Prevention Needs Assessment XXX County Crosstabs Report	2018 XXX County Census Data/ School Enrollment Data	

Evidence Based	*Provide rationale for program being evidence-based, promising, or cultural**	*Cultural practices need to be transposed into an acceptable format such as the model by Caroline Cruz

	Person Responsible: Prevention Specialist		
Selected Strategies	**Short**	**Long**	Not real data from Hill County)
Dissemination of Information Environmental Approach	Increase the number of students (8,10,12 combined) responding "Slight, Moderate, or Great Risk" to the Question: How much do you think people risk harming themselves if they take one or two drinks of an alcoholic beverage every day from 84.6% in 2018 to 88% in 2022. (2018 PNA Crosstab, page 17)	Reduce 30-Day Alcohol Use in grades 8,10, and 12 combined from 31.7% in 2018 to 25% in 2026. (2018 County PNA Crosstab, Pg 24)	
Dissemination of Information Prevention Education	Increase the number of students (8,10,12 combined) responding "Very Wrong" to the Question: How wrong do your parents feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day from 60.8% in 2018 to 65% in 2022. (2018 PNA Crosstab, Pg 7)	Reduce 30-Day Alcohol Use in grades 8,10, and 12 combined from 31.7% in 2018 to 25% in 2026. (2018 County PNA Crosstab, Page 24)	
Prevention Education Problem Id and Referral	Decrease the number of students (8,10,12 combined) who report 10 or more risk factors from 72% in 2018 to 69% in 2022 (2018 County Profile Pg 12)	Reduce 30-Day Alcohol Use in grades 8,10, and 12 combined from 31.7% in 2018 to 25% in 2026. (2018 County PNA Crosstab, Pg 24)	

Alternatives Activities Community Based Process	Decrease the number of students (8,10,12 combined) responding "yes" or "YES!" to the question: When I am an adult, I will smoke marijuana from 15.4% in 2018 to 11% in 2022. (2018 PNA Crosstab, Pg 16)	Reduce 30-Day Marijuana Use in grades 8,10, and 12 combined from 22.1% in 2018 to 15%in 2026 (2018 County PNA Crosstab, Pg 24)
Prevention Education	Decrease the number of students (8th,10th,12th combined) responding 'yes" or "YES!" to the question: When I am an adult, I will smoke marijuana from 15.4% in 2018 to 10% in 2022. (2018 PNA Crosstab, Pg 16)	Reduce 30-Day Marijuana Use in grades 8,10, and 12 combined from 22.1% in 2018 to 15%in 2026 (2018 County PNA Crosstab, Pg 24)
Prevention Education Alternative Activities	Increase the number of students who think it is a great risk of harming themselves (physically or in other ways) if they use methamphetamie from 72% in 2018 to 76% in 2022 (2018 PNA Crosstab Pg 17)	Reduce 30 day Methamphetamine use among 8,10,12 grades combined from 6.5% to 2.5% (2018 PNA Crosstab Pg 26)
CSAP Strategies *1. Dissemination of Information* *2. Prevention Education* *3. Alternative Activities* *4. Community Based Process* *5. Environmental Approach* *6. Problem Identification and Referral*	2018 XXX County PNA Crosstab Report	2018 XXX County PNA Crosstab Report

COUNTY: ***(PFS) Hill***

Long Term Goal:	(PFS) 30-Day Alcohol Use Among Youth 9-20 y/o
	(PFS) 30-Day Marijuana Use Among Youth 9-20 y/o
	(PFS) 30-Day Methamphetamine Use Among Youth 9-20 y/o
Short Term Goals:	RF Perceived Risk of Drug Use (Peer and Individual Domain)
	RF Parental Attitudes Favorable to Drug Use (Family Domain)
	RF Number of Students with Ten or More Risk Factors
	PF Opportunities for Prosocial Involvement (Community Domain)
	RF Gang Involvement (Peer and Individual Domain)

Action Plan

		Community Engagement Process						Funding
Activity by CSAP Strategy	**Description/ Evidence-Based Policy, Program, or Practice (See Approved List)**	**When**	**How**	**Who**	**Responsible Party**	**Resources Needed/ Training**	**Who Should Know**	**Will BG or PFS money be expended for this strategy?**
Dissemination of Information								
DOI Engaging Parents Toolkit (Parenting Montana)-Indirect	Deliver/Educate/Hand-out media materials to Community Health Partners, Schools, and Public (P1, P2, P3)	March 2019 to March 2020	In person	PS & Public Schooles	PS	MSU Webex	All Community Partners/ General Public/PS	Yes PFS
Prevention Education								
PE/EB Groups for Children of Substance Abusers	Work with DFS and Schools to identify high risk youth to set up edu series (P1, P2)	Start this Spring (April) for classess to start in the Fall	Create school and DFS team	In-person meeting/emails/school partnerships	HS counselor and PS	EBP List, information and Costs	Schools, DFS, Tx providers, PS	No PFS
Alternative Activities								
AA Mentoring Programs	Educate 2 schools in County on effective mentorship and implement a school mentoring program through MBI (P2)	5/1/2019 through September 2019	In person. School team	In-person meeting/emails/school partnerships	PS and School team	MBI/Mentor Training	Schools/PS	Yes PFS
Community Based Process								
CBP CONNECT	County	June 2020	Collaboration	CONNECT Team	PS	Ongoing CONNECT training	Partners/ General	No PFS
CBP Communities that Care PLUS	Participate in CTC Plus Initiative	Sept 2019 through Sept 2022	Community Collaboration	CDB & CTC & PS	CTC	Training in CTC	All Community Partners/ General Public/PS	Yes PFS
Environmental Approach								
EA Restricting Alcohol Sales at Public Events	Work with coaltion to develop plan to update ordinance	June 2019 through Sept 2020	Community Collaboration	Sub-group of coaltion and PS	PS	Environmental Education/ OrdianceTraining	City Council/PS	No PFS
Problem Ident & Referral								
PIR Teen Courts	Work with Justice Court and assist DFS with these families	June 2019 through July 2020	Work with DFS and Courts	Coalition and PS	PS	Training on Teen Courts	Justice Court/PS	No PFS

AMDD Community-Based Prevention Logic Model

Community: (BG) Dawson

30-Day Alcohol Use Among Youth (8th,10th, 12th Combined)

	Problem	**Factors**	**Focus Population(IOM)**	**At-Risk Category**
Youth	(BG) 30-Day Alcohol Use Among Youth in Grades 8, 10,12	RF Parental Attitudes Favorable to Antisocial Behavior (Family Domain)	Universal- Indirect General Population- 8,902 Universal-Direct Students in 8th-12th grade-300 Universal Direct-Parents of students in 8th-12th-650	
Measures and Sources	2018 MT PNA Dawson County Profile Report	2018 MT PNA Dawson County Crosstab Report	Universal-Direct Universal-Indirect Selective Indicated Populations: Census Info and Demographics	
Evidence Based	*Provide rationale for program being evidence-based, promising, or cultural**	*Cultural practices need to be transposed into an acceptable format such as the model by Caroline Cruz		

	Person Responsible: WITS SAMPLE	
Selected Strategies		
	Short	**Long**
Dissemination of Information Alternative Activities Prevention Education	Increase the number of students (8,10,12 combined) responding "Very Wrong" to the Question: How wrong do your parents feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day from 52% in 2018 to 55% in 2022. (2018 Dawson PNA Crosstab, Page 7)	Reduce 30-Day Alcohol Use in grades 8,10, and 12 combined from 42% in 2018 to 35% in 2026. (2018 Dawson County PNA Crosstab, Page 24)
CSAP Strategies *1. Dissemination of Information* *2. Prevention Education* *3. Alternative Activities* *4. Community Based Process* *5. Environmental Approach* *6. Problem Identification and Referral*	2018 MT PNA Dawson County Crosstab Report	2018 MT PNA Dawson County Profile Report

Community:

Long Term Goal:	(BG) 30-day Alcohol Use Among Youth in grades 8,10,12
Short Term Factor:	Parental Attitudes Favorable Towards Antisocial Behavior (Family Domain)

Action Plan

Activity by CSAP Strategy	Description/ Evidence-Based Policy, Program, or Practice (See Approved List)	Community Engagement Process						Funding
		When	How	Who	Responsible Party	Resources Needed/ Training	Who Should Know	Will BG or PFS money be expended for this strategy?
Dissemination of Information								
DOI Engaging Parents Toolkit (Parenting MT)-Indirect	Press releases, radio ads, deliver brochures and other media throughout the community.	March 2019-Sept 2020	Distribute Materials	PS, Coalition Members, Community Partners	PS	Parenting MT Toolkit materials	Community Partners, Public, RTAL's, AMDD Staff	Yes BG
(RECURRING)								
DOI SAMHSA Town Hall Grant	Received SAMHSA $750 mini-grant. Plan and host Town Hall meeting for community.	March 2019-September 2019	Plan and host	PS, Coalition Members	PS	SAMHSA Grant funds	Community Partners, Public, Coalition	No BG
(ONE TIME INTERVENTION!!!!)								
Prevention Education								
PE/EB Parenting and Family Management Classes	Active Parenting Now Classes offered twice per year in the county (P1)	March 2019-Sept 2020	Instruct, Support	PS, Health Dept, MSU Extension	Prevention Specialist	Active Parenting Train the Trainer	Coalition Members, Key Steakholders	Yes BG
(SESSION-BASED)								
Alternative Activities								
AA Drug-Free Dances & Parties	After-prom party support for Parent & Teacher Association (PTA)	March 2019-May 2020	Support, provide education & materials	PTA, PS, School, Coalition, Student Council	PTA, School	N/A	School, Students, Parents	No BG
(ONE-TIME)								
Community Based Process								
Environmental Approach								
Problem Ident & Referral								

RF Low Neighborhood Attachment (Community Domain)
RF Community Disorganization (Community Domain)
RF Laws & Norms Favorable to Drug Use (Community Domain)
RF Perceived Availibility of Drugs (Community Domain)
RF Perceived availibility of Handguns (Community Domain)
RF Parental Attitudes Favorable to Antisocial Behavior (Family Domain)
RF Poor Family Management (Family Domain)
RF Family Conflict (Family Domain)
RF Family History of Antisocial Behavior (Family Domain)
RF Parental Attitudes Favorable to Drug Use (Family Domain)
RF Low Commitment to School (School Domain)
RF Academic Failure (School Domain)
RF Rewards For Antisocial Behavior (Peer and Individual Domain)
RF Attitudes Favorable to Drug Use (Peer and Individual Domain)
RF Attitudes Favorable to Antisocial Behavior (Peer and Individual Domain)
RF Depressive Symptoms (Peer and Individual Domain)
RF Sensation Seeking (Peer and Individual Domain)
RF Rebelliousness (Peer and Individual Domain)
RF Early Initiation of Antisocial Behavior (Peer and Individual Domain)
RF Perceived Risk of Drug Use (Peer and Individual Domain)
RF Intention to Use Drugs (Peer and Individual Domain)
RF Gang Involvement (Peer and Individual Domain)
RF Early Initiation of Drug Use (Peer and Individual Domain)
RF Number of Students with Ten or More Risk Factors
RF Interaction With Antisocial Peers (Peer and Individual Domain)
PF Opportunities for Prosocial Involvement (Community Domain)
PF Rewards for Prosocial Involvement (Community Domain)
PF Family Attachment (Family Domain)
PF Opportunities for Prosocial Involvement (Family Domain)
PF Rewards for Prosocial Involvement (Family Domain)
PF Opportunities for Prosocial Involvement (School Domain)
PF Rewards for Prosocial Involvement (School Domain)
PF Belief in the Moral Order (Peer and Individual Domain)
PF Religiosity (Peer and Individual Domain)
PF Interaction with Prosocial Peers (Peer and Individual Domain)
PF Prosocial Involvement (Peer and Individual Domain)
PF Rewards for Prosocial Involvement (Peer and Individual Domain)
CF Age of Initiation
CF Sources of Obtaining Alcohol
CF Perceived Harmfulness of Drugs
CF Average Age of First Subtance Use
CF Heavy ATOD and Antisocial Behaviors
CF PNA Specific Question
CF Focus Group Data
CF Community Readiness Scores

TPF American Indian Identity
TPF Ethnic Identity
TPF Involvement In American Indian Cultural Practicies
TPF Greater Importance Ascribed to Traditional Indian Values
TPF Cultural Pride/ Spirituality
TPF Living By Traditional Way
TPF Raised in Rural Reservation Area
TPF Individual Characteristics (Sence of Efficacy)
TPF Family Influence (Close Relationship With Parents)
TPF Community Influences
TRF Being More Engaged in Traditional Activities (Suicidal Ideation)
TRF Native Traditionalism
TRF Historical Trauma (Loss of Cultural Traditions)
TRF Participation in Generic (vs. Tailored) Cultural Activities
TRF Established Norms of Alcohol Use on Reservation

(BG) Beaverhead
(BG Blackfeet Nation
(PFS)Blackfeet Nation
(PFS) Blaine
(BG) Butte-Silverbow
(BG) Cascade
(BG) Carbon
(BG) CSKT
(PFS) CSKT
(BG) Crow
(PFS) Crow
(PFS) Big Horn
(BG) Custer
(BG) Dawson
(PFS) Dawson
(PFS) Deer Lodge
(BG) Deer Lodge
(BG) Fallon
(BG)Fergus
(BG)Flathead
(BG) Fort Belknap
(PFS) Fort Belknap
(BG) Fort Peck
(PFS) Fort Peck
(BG) Gallatin
(PFS) Glacier
(PFS) Hill
(BG) Jefferson

(PFS) Lake
(BG) Lewis & Clark
(BG) Lincoln
(PFS) Lincoln
(BG) Madison
(PFS) Madison
(BG) Mineral
(BG) Missoula
(BG) Northern Cheyenne
(PFS) Northern Cheyenne
(BG) Park
(BG) Phillips
(BG) Pondera
(BG) Powell
(PFS) Powell
(BG) Ravalli
(BG) Richland
(BG) Rocky Boy
(PFS) Rocky Boy
(PFS) Roosevelt
(PFS) Rosebud
(BG) Sanders
(BG) Stillwater
(BG) Toole
(BG) Valley
(BG) Yellowstone

Dissemination of Information
Prevention Education
Alternative Activities
Community Based Process
Environmental Approach
Problem Identification and Referral

(BG) 30-Day Binge Drinking Among High School Students
(BG) 30-Day Illicit Drug Use Among Youth Ages 12-17
(BG) 30-Day Binge Drinking in Adults Ages 18-65+
(BG) 30-Day Alcohol Use Among Youth in Grades 8, 10,12
(BG) 30-Day Marijuana Use Among Youth in Grades 8, 10, 12
(PFS) 30-Day Alcohol Use Among Youth 9-20 y/o
(PFS) 30-Day Marijuana Use Among Youth 9-20 y/o
(PFS) 30-Day Methamphetamine Use Among Youth 9-20 y/o

Yes BG

No BG
Yes PFS
No PFS

Children of Substance Users
Pregnant Women/ Teens
Drop-Outs
Violent and Delinquent Behavior
Mental Health Problems
Economically Disadvantaged
Physically Disabled
Abuse Victims
Already Using Substances
Homeless and/or Runaway
LGBTQ
Military
College
Youth in Foster Care
Youth On Probation
Youth on Reservation
PFS- Foster Care
PFS-On Reservation
PFS- On Probation

DOI Help Lines-Indirect
DOI Clearinghouse and other information resource centers-Indirect
DOI Resource Directories-Indirect
DOI Social Norms Media Campaign- Indirect
DOI Media Advocacy-Indirect
DOI Media Campaigns-Indirect
DOI Brochures/handbooks-Indirect
DOI Radio and Television Public Service Announcements-Indirect
DOI Speaking Engagements/Community Presentations-Direct
DOI Town Hall Meetings-Direct
DOI Health Fairs-Direct
DOI Newspaper Stories-Indirect
DOI Engaging Parents Toolkit (Parenting Montana)-Indirect
DOI Sticker Shock Campaign-Indirect

PE/EB Classroom and Small Group Sessions
PE/EB Parenting and Family Management Classes

PE/EB Peer Leader and Peer Helper Programs
PE/EB Education Programs for Youth Groups
PE/EB Groups for Children of Substance Abusers
PE/EB Cultural Program
AA Drug-Free Social and Recreational Activities
AA Drug-Free Dances and Parties
AA Youth and Adult Leadership Activities
AA Community Drop-in Centers
AA Community Service Activities
AA Mentoring Programs

CBP Community and Volunteer Training
CBP Systematic Planning
CBP Community Mobilization
CBP Accessing Services and Funding
CBP Coalition Building
CBP DUI Task Force
CBP Local Advisory Councils
CBP Communities that Care PLUS
CBP Technical Assistance to Coalition Members
CBP CONNECT

EA ATOD Policy Advocacy, Enactment, or Implementation
EA Social Host Laws
EA Increased ATOD Taxes
EA Policies to Reduce ATOD Outlet Density
EA Restricting Alcohol Sales at Public Events
EA Happy Hour Restrictions
EA Keg Registration
EA ATOD-Free School Policies
EA T/A to communities to maximize local enforcement procedures governing the availability and distri
EA The Review and Modification of ATOD Advertising Practices
EA ATOD Product Pricing Strategies
EA Beverage Server Training or RASS training
EA Retailer Recognition- Reward & Reminder
EA ATOD Compliance Checks
EA Tip Line
EA Party Patrols
EA Neighborhood Surveillance/Watches
EA Court Monitoring
EA Shoulder Tap Programs

PIR Driving-while-intoxicated Education Programs
PIR Employee Assistance Programs

PIR Student Assistance Programs
PIR Teen Courts
PIR on-line screening e-checkup(e-CHUG)

ibution of ATOD.

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots ( ) Yes (●) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Pregnant women continue to receive priority admission for treatment. This has been and will continue to be evaluated on an ongoing basis through Quality Assurance Division's on-site annual reviews, yearly continuation application information, monthly and quarterly reports provided by the SAMS system. Current contracts require programs to provide pregnant women an assessment within 48 hours of request for services and be admitted for treatment services within 5 working days of diagnosis. If appropriate, a referral to a higher level of care made at that time. Programs are required to have partnerships with local facilities to provide prenatal care and are encouraged to use Targeted Case Management to refer and assist pregnant women to obtain prenatal care if they are not participating in prenatal care.

Programs are required to provide interim services within 48 hours if they cannot admit the woman to treatment. Montana, historically, does not have a waiting list for this population due to the priority admission status.

MCDC ensures pregnant women receive treatment as needed and requested or finds the appropriate placement within the State-Approved Provider System. The nursing staff at MCDC continues to receive additional training in order to manage and treat pregnant women in the facility.

Programs continue to coordinate with other service agencies in communities and the Addictive and Mental Disorders Division has encouraged providers to work within their communities to take a greater responsibility in the provision of services needed to support the recovery of all individuals.

Revision Added 12-23-2019:
Should identified compliance problems related to activities and services related to PWWDC and/or PWID, the Department will require the contractor to develop a corrective action plan detailing the contractor proposes to undertake to resolve the compliance problems. The Department will review and monitor the contractor's processes as outlined in the corrective action plan. See page 12, Section 10 of the SUD Treatment Contract Language Sections D, E, F, & G.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (•) No
b)	Automatic reminder system associated with 14-120 day performance requirement	(•) Yes ( ) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Pregnant women continue to receive priority admission for treatment. This has been and will continue to be evaluated on an ongoing basis through Quality Assurance Division's on-site annual reviews, yearly continuation application information, monthly and quarterly reports provided by the SAMS system. Current contracts require programs to provide pregnant women an assessment within 48 hours of request for services and be admitted for treatment services within 5 working days of diagnosis. If appropriate, a referral to a higher level of care made at that time. Programs are required to have partnerships with local facilities to provide prenatal care and are encouraged to use Targeted Case Management to refer and assist pregnant women to obtain prenatal care if they are not participating in prenatal care.

Programs are required to provide interim services within 48 hours if they cannot admit the woman to treatment. Montana, historically, does not have a waiting list for this population due to the priority admission status.

MCDC ensures pregnant women receive treatment as needed and requested or finds the appropriate placement within the State-Approved Provider System. The nursing staff at MCDC continues to receive additional training in order to manage and treat pregnant women in the facility.

Programs continue to coordinate with other service agencies in communities and the Addictive and Mental Disorders Division has encouraged providers to work within their communities to take a greater responsibility in the provision of services needed to support the recovery of all individuals.

Revision Added 12-23-2019:
Should identified compliance problems related to activities and services related to PWWDC and/or PWID, the Department will require the contractor to develop a corrective action plan detailing the contractor proposes to undertake to resolve the compliance problems. The Department will review and monitor the contractor's processes as outlined in the corrective action plan. See page 12, Section 10 of the SUD Treatment Contract Language Sections D, E, F, & G.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (•) No
c)	Established co-located SUD professionals within FQHCs	(•) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Montana does not meet the requirement for TB agreements, due to the numbers are below the threshold. Montana Tuberculosis Prevention and Control Program under the DPHHs Communicable Disease Epidemiology Section provides all the training, technical assistance, medication, treatment, and tracking of all identified individuals with TB in the State of Montana regardless of income, diagnosis, or circumstance. Services in most cases are accessed through the county health departments but if one is not available, the program works with all medical providers.

For the SUD programs...
The evaluators with the Quality Assurance Division (QAD) review whether programs are appropriately exploring high-risk behaviors of PWID and encouraging clients to seek testing for HIV, Hepatitis A, B, & C, tuberculosis, and other identified medical issues if appropriate. This is done on an annual on-site visit. If issues are identified, program officers work with providers to develop a corrective action plan and a regular on site visit schedule. Further monitoring occurs through the data from our treatment data system (Substance Abuse Management System (SAMS)) on a monthly basis. The evaluation process reviews TB policy and procedures in each of the state approved programs.

The Montana Chemical Dependency Center Medical Director or appropriate personnel reviewed medical policies, procedures and protocols. All admissions receive education on HIV, Hepatitis A, B, & C, tuberculosis and identified medical conditions and were either tested or encouraged to be tested. Those clients tested for HIV, Hepatitis A, B, & C, tuberculosis received Pre and Post counseling and the needed medical treatment. This is monitored internally within MCDC by the Medical Director on a monthly basis.

The contracted State-Approved programs sign assurances and have written into their contracts pertaining to reporting when obtaining 90% of treatment capacity, 5 day performance requirement, and outreach requirements. These policies were reviewed for compliance during on site evaluations. Montana programs are not allowed to have waiting lists for this population as they are to provide interim services upon contact and are required to admit within 5 days. If they can admit the person into the facility within 5 days, they are required to work with the individual to see if he/she is able to work with a different provider with openings. This requirement enables this population to be treated as needed. Monitoring occurs through 4 different avenues - First through monthly monitoring of services provided to this population by the Bureau through the SAMS system and invoicing system; second, through annual site visits performed by Quality Assurance; third, through program officer site visits for identified issues; and fourth, through fiscal audit reviews

AMDD has worked with Public Health and Safety Division's TB and infectious disease programs to gain access to their service providers and to provide training to the State Approved Programs as part of a planned response to address the TB and other related issues in Montana. Monitoring is occurring as indicated in the above paragraph.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ( ) Yes (●) No

b) Establishment or expansion of tele-health and social media support services (●) Yes ( ) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ( ) Yes (●) No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)? ( ) Yes (●) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? (●) Yes ( ) No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ( ) Yes (●) No

If yes, plese provide a brief description of the elements and the arrangement

Montana HIV/STD Prevention Program under the DPHHs Communicable Disease Epidemiology Section provides all the training, technical assistance, assistance with finding treatment, and tracking of all identified individuals with HIV/STD/Hep C in the State of Montana regardless of income, diagnosis, or circumstance. Services in most cases are accessed through the county health departments but if one is not available, the program works with all medical providers.

The evaluators with the Quality Assurance Division (QAD) review whether programs are appropriately exploring high-risk behaviors

of PWID and encouraging clients to seek testing for HIV, Hepatitis A, B, & C, tuberculosis, and other identified medical issues if appropriate. This is done on an annual on-site visit. If issues are identified, program officers work with providers to develop a corrective action plan and a regular on site visit schedule. Further monitoring occurs through the data from our treatment data system (Substance Abuse Management System (SAMS)) on a monthly basis. The evaluation process reviews HIV policy and procedures in each of the state approved programs. The Bureau has worked with the Governor's HIV Council to provide information about up-to-date policies and procedures to work with this special population. This is monitored as indicated above.

The Montana Chemical Dependency Center Medical Director or appropriate personnel reviewed medical policies, procedures and protocols. All admissions receive education on HIV, Hepatitis A, B, & C, tuberculosis and identified medical conditions and were either tested or encouraged to be tested. Those clients tested for HIV, Hepatitis A, B, & C, tuberculosis received Pre and Post counseling and the needed medical treatment. This is monitored internally within MCDC by the Medical Director on a monthly basis.

The contracted State-Approved programs sign assurances and have written into their contracts pertaining to reporting when obtaining 90% of treatment capacity, 5 day performance requirement, and outreach requirements. These policies were reviewed for compliance during on site evaluations. Montana programs are not allowed to have waiting lists for this population as they are to provide interim services upon contact and are required to admit within 5 days. If they can admit the person into the facility within 5 days, they are required to work with the individual to see if he/she is able to work with a different provider with openings. This requirement enables this population to be treated as needed. Monitoring occurs through 4 different avenues - First through monthly monitoring of services provided to this population by the Bureau through the SAMS system and invoicing system; second, through annual site visits performed by Quality Assurance; third, through program officer site visits for identified issues; and fourth, through fiscal audit reviews

AMDD has worked with Public Health and Safety Division's HIV and infectious disease programs to gain access to their service providers and to provide training to the State Approved Programs as part of a planned response to address the hepatitis B C and other related PWID issues in Montana. Monitoring is occurring as indicated in the above paragraph.

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — ◉ Yes ○ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ◉ Yes ○ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ◉ Yes ○ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ◉ Yes ○ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ○ Yes ◉ No
- **f)** Explore expansion of services for:
  - **i)** MAT — ◉ Yes ○ No
  - **ii)** Tele-Health — ◉ Yes ○ No
  - **iii)** Social Media Outreach — ◉ Yes ○ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ○ Yes ◉ No
- **b)** Establish a program to provide trauma-informed care — ◉ Yes ○ No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ◉ Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — ◉ Yes ○ No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ○ Yes ◉ No
- **b)** An organized referral system to identify alternative providers? — ○ Yes ◉ No
- **c)** A system to maintain a list of referrals made by religious organizations? — ○ Yes ◉ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ◉ Yes ○ No
- **b)** Review of current levels of care to determine changes or additions — ◉ Yes ○ No
- **c)** Identify workforce needs to expand service capabilities — ◉ Yes ○ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

FY 22 (10/1/2021-9/30/22) - 5 programs will receive an Independent Peer Review

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

MT State Approval certification is required for access to block grant funding and Medicaid provider enrollment. Residential Treatment and Inpatient SUD treatment is required to additionally have a license by the Quality Assurance Division of DPHHS for SUD Treatment.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Substance Use Disorder ARM:
https://rules.mt.gov/gateway/ChapterHome.asp?Chapter=37%2E27

Mental Health ARM:
https://rules.mt.gov/gateway/ruleno.asp?RN=37.106.1902

Footnotes:

MT Contract with SUD Treatment Provider

FFY2019-2020

HIPAA Statements/References to

LAWS/Warranties/Confidentiality from "Contract"

SECTION 11. COMPLIANCE WITH LAWS/WARRANTIES

A. The Contractor must comply with all state and federal laws, rules, regulations, ordinances, and executive orders applicable to the performance of the Services under this Contract. Attachment F to this Contract contains a list of state and federal authorities. The Contractor must assure that all subcontractors comply with all applicable laws.

B. Civil Rights. The Contractor may not discriminate in any manner against any person on the basis of race, color, national origin, age, physical or mental disability, marital status, religion, creed, sex, sexual orientation, political beliefs, genetic information, veteran's status, culture, social origin or condition, ancestry, or an individual's association with individuals in any of the previously mentioned protected classes in the performance of this Contract or in the delivery of Montana State services or funding on behalf of the State of Montana.

C. The Contractor must submit the assurances, where applicable, set forth in Attachment F and attached as Attachment I to this Contract prior to commencement of work under this Contract.

D. The Contractor represents and warrants that the Contractor is legally authorized under state and federal business and tax legal authorities to conduct business in accordance with this Contract.

E. The Contractor represents and warrants that it is an independent contractor and that its employees, agents and subcontractors are not employees of the State of Montana. The Contractor may not in any manner represent or maintain the appearance of being employees of the State of Montana.

F. The Contractor must comply with all applicable Workers' Compensation requirements.

G. The Contractor must pay all state, federal, social security, unemployment insurance, and all other taxes, assessments, or contributions due and payable to the State of Montana and/or the United States in connection with the Services to be performed under this Contract. The Contractor must hold the State of Montana harmless from any liability on account of any such taxes or assessments.

SECTION 14. CONFIDENTIALITY

A. Personal Information

1. During the term of this Contract, the Contractor, its employees, subcontractors and agents must treat and protect as confidential all material and information the Department provides to the Contractor or which the Contractor acquires on behalf of the Department in the performance of this Contract which contains the personal information of any person.

2. In its use and possession of personal information, the Contractor must conform to security standards and procedures meeting or exceeding current best business practices. Upon the Department's request, the Contractor will allow the Department to review and approve any specific security standards and procedures of the Contractor.

B. Notice by Contractor of Unauthorized Disclosures or Uses of Personal Information

1. Immediately upon discovering any unauthorized disclosure or use of personal information by the Contractor, its employees, subcontractors, agents, the Contractor must confidentially report the disclosure or use to the Department in detail, and must undertake immediate measures to retrieve all such personal information and to prevent further unauthorized disclosure or use of personal information.

C. Notice by Contractor of Investigations, Complaints, Litigation Concerning the Use and Protection of Personal Information

1. The Contractor must provide the Department with written notice within five workdays of the Contractor receiving notice of any administrative action or litigation threatened or initiated against the Contractor based on any legal authority related to the protection of personal information.

2. With its notice, the Contractor must provide the Department with copies of any relevant correspondence, pleadings, papers, administrative or legal complaints and determinations.

D. Contract Information

The Contractor must hold in strict confidence any data, findings, results, or recommendations obtained or developed by the Contractor in connection with the

Services under this Contract, including but not limited to, information and data given to the Contractor by the Department, its agents or contractors or any other source.

E. Access/Use of Confidential Information

The Contractor may not access or use personal, confidential, or other information obtained through the Department, its agents and contractors, unless the Contractor does so:

1. in conformity with governing legal authorities and policies;

2. with the permission of the persons or entities to whom or which the information pertains; and

3. with the review and approval by the Department prior to use, publication or release.

F. The information contained within this Contract and attachments, inclusive of Contractor's proposal and its attachments, if any, and information otherwise provided to the Department in relation to this contractual relationship is not confidential and is available for public inspection and copying unless determined in accordance with federal or state law to be confidential as personal consumer, recipient or employee information or as business/corporate proprietary information that is protected from release. To any extent required or allowed by law, the Department has the right to use for public purposes and to disclose to the public contractual information inclusive of reports, evaluations, statistics, and other management and performance information related to this Contract.

SECTION 16. COMPLIANCE WITH THE FEDERAL HIPAA AND HITECH PRIVACY AND SECURITY REQUIREMENTS

A. If the Contractor is a "Business Associate" as defined at 45 C.F.R. § 160.103, it must comply with the privacy and security requirements for functioning as a "business associate" of the Department or as a "covered entity" under HIPAA and HITECH. In addition to executing this Contract, the Contractor must execute the Business Associate Agreement attached to this Contract as Attachment H.

THE PARTIES AGREE AS FOLLOWS:

1. Business Associate Status

a. The Department is subject to and must comply with provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 U.S.C. § 1320d-d8, and the Health Information Technology for

Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the American Recovery and Reinvestment Act of 2009, as codified at 42 U.S.C. §§ 300jj et seq. and §§ 17901, et seq. and the implementing regulations for the two acts at 45 CFR Parts 160, 162 and 164.

b. The Department has determined it is a hybrid entity as defined in the implementing regulations, that is a covered entity performing both covered and non-covered functions. Under the HIPAA and HITECH and the implementing regulations, the Business Associate, as an entity that performs or assists in the performance of an administrative or data function for the Department involving the use or disclosure of protected health information (PHI) for the Department, is acting as a business associate of a covered entity.

2. Definitions that Apply to This Agreement

Terms used in this Agreement have the same meaning as those terms in the HIPAA and HITECH Acts and the implementing regulations.

3. Status as a Business Associate

The Business Associate agrees that it is a Business Associate of the Department, as defined at 45 CFR § 160.103, and further agrees that it is obligated to comply with the terms of this Agreement and with the requirements of the HIPAA and HITECH Acts and the implementing regulations.

4. Obligations of Business Associate

The Business Associate, as a business associate of the Department, must:

a. use or disclose PHI, including E-PHI, only as is permitted or required by this Agreement, in compliance with the Department's minimum necessary standard policies and procedures, or by applicable law inclusive of 45 CFR Parts 160, 162 and 164;

b. use appropriate safeguards to prevent use or disclosure of PHI and E-PHI other than as provided for by this Agreement or by law;

c. implement appropriate administrative, physical and technical security safeguards as set forth in § 164.306, § 164.308, and § 164.312, that reasonably and appropriate protect the confidentiality, integrity, and availability of PHI and prevent use or disclosure of the PHI other than as provided for by this Agreement;

d. mitigate to the extent practicable and as may be directed by the Department any harmful effect that is known to the Business Associate of a use or disclosure of PHI by the Business Associate that is in violation of the requirements of this Agreement;

e. report in a timely manner as required by law and this Agreement to the Department any use or disclosure of the PHI not provided for by this Agreement inclusive of uses and disclosures of information that are not in compliance with the minimum necessary standard;

f. report to the Department any security incident of which it becomes aware, and at the request of the Department must identify: i) the date of the security incident, ii) the scope of the security incident, iii) the Business Associate's response to the security incident, and iv) the identification of the party responsible for causing the security incident, if known;

g. enter, as required by 45 CFR § 164.504, into Business Associate Agreements containing the terms and conditions as required by the HIPAA and HITECH Acts and the implementing regulations and as are stated in this Agreement, with any subcontractors performing services in relation to the services being provided by the Business Associate for the Department that involve PHI; and

h. make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of the Department, available to the Department, or to the Secretary of the Federal Department of Health and Human Services in accordance with 45 CFR § 164.408, in a time and manner prescribed by the Department or designated by the Secretary, for purposes of the Secretary determining the Department's and the Business Associate's compliance with the Privacy Regulation, the Security Regulation, and the HITECH Act;

i. document disclosures of PHI and collect information related to those disclosures necessary for the Department to respond to a request by a person for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528 and Section 13405(c) of the HITECH Act;

j. provide to the Department or a person, in time and manner prescribed by the Department, documentation necessary for the Department to respond to a request by a person for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Notwithstanding 45 CFR § 164.528(a)(1)(i), the Business Associate must document disclosures of PHI made through an electronic health record to carry out treatment, payment or health care operations as provided by 45 CFR § 164.506 in the six years prior to the date on which the accounting is requested, and to collect

information related to such disclosures as required by the Secretary in regulation pursuant to Section 13405(c)(2) of the HITECH Act;

k. implement a response program, in compliance with Section 13402 of the HITECH Act and implementing regulations, and Subpart D of 45 CFR Part 164 that specifies the actions to be taken when the Business Associate detects or becomes aware of unauthorized access to information systems. The response program must include the following features:

(i) The Business Associate must notify the Department, by facsimile or telephone, of any breach or suspected breach of its security related to areas, locations, or computer system which contain unsecured PHI, including, without limitation, any instance of theft, unauthorized access by fraud, deception, or other malfeasance or inadvertent access (an "incident") in accordance to 45 CFR § 164.410, as promptly as possible, upon having reason to suspect that an incident may have occurred or determining the scope of any such incident, but in no event later than two (2) calendar days upon having reason to suspect that an incident may have occurred;

(ii) In the event of any incident, the Business Associate must provide to the Department, in writing, those details concerning the incident as the Department may request, and must cooperate with the Department, its regulators and law enforcement to assist in regaining possession of the unsecured PHI and in preventing its further unauthorized use, and take any necessary remedial actions as may be required by the Department to prevent other or further incidents;

(iii) If the Department determines that it may need to notify any person(s) as a result of such incident that is attributable to the Business Associate's breach of its obligations under this Agreement, the Business Associate must bear all reasonable direct and indirect costs associated with the determination, including, without limitation, the costs associated with providing notification to the affected person, providing fraud monitoring or other services to affected persons and any forensic analysis required to determine the scope of the incident;

(iv) The Business Associate, working in cooperation with the Department, must update the notice provided to the Department under this Agreement of the incident to include, to the extent possible and as soon as possible, the identification of each person whose unsecured PHI has been, or is reasonably believed by the Business Associate or the Department to have been accessed, acquired, used or disclosed during the incident and must provide any of the following

information the Department is required to include in its notice to the person pursuant to 45 CFR § 164.404(c):

(A) A brief description of what happened, including the date of the incident and the date of the discovery of the incident, if known;

(B) A description of the types of unsecured PHI that were involved in the incident (e.g., Social Security Number, full name, date of birth, address, diagnosis);

(C) Any steps the person should take to protect themselves from potential harm resulting from the incident;

(D) A brief description of what is being done to investigate the incident, mitigate the harm, and protect against future incidents;

(E) Contact procedures for persons to ask questions or learn additional information which shall include a toll-free number, an e-mail address, website, or postal address;

(F) This additional information must be submitted to the Department immediately at the time the information becomes available to the Business Associate;

(v) limit its use and disclosure of PHI created or received by the Business Associate from or on behalf of the Department to uses or disclosures as are permitted to the Business Associate under the applicable requirements of 45 CFR § 164.504(e) and the HITECH Act and the terms of this Agreement. The Business Associate must also comply with the additional requirements of Subtitle D of the HITECH Act that relate to privacy and that apply to covered entities and to the Business Associate as a business associate; and

(vi) respond to a person's request under 45 CFR § 164.522(a)(1)(i)(A) that the Business Associate restrict the disclosure of the person's PHI.

Permitted Uses, Disclosures and Limitations

a. Except as otherwise limited in this Agreement, the Business Associate may use or disclose PHI on behalf of, or to provide services to, the Department for the following purposes, if such use or disclosure of PHI would not violate the requirements of the HIPAA and HITECH Acts and the implementing regulations if done by the Department or otherwise violate the minimum necessary policies and procedures of the Department: Substance Use Disorders and Co-occurring Treatment Services.

b. The Business Associate may use PHI to report violations of federal and state laws to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1) and (2).

c. The Business Associate, as required by 45 CFR § 164.504(e)(1)(iii), must terminate any business associate agreement with a subcontractor that violates the requirements of this Agreement or the applicable law.

d. The Business Associate shall not directly or indirectly receive remuneration in exchange for PHI that is created or received by the Business Associate from or on behalf of the Department.

6. Use and Disclosure for Business Associate's Purposes

a. The Business Associate must use and disclose PHI that is created or received by the Business Associate from or on behalf of the Department in compliance with each applicable requirement of 45 CFR § 164.504(e) and the HITECH Act.

b. The Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate provided that:

(i) the disclosures are required by law;
(ii) the disclosures are expressly authorized in this Agreement by the Department;
(iii) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only for the purpose for which it was disclosed to the person; and
(iv) the Business Associate requires the person to whom the information is disclosed to report immediately any incident of which it is aware in which the confidentiality of the information has been breached.

c. The Business Associate may only use PHI for Data Aggregation purposes if the Department in this Agreement expressly authorizes those purposes and the Data Aggregation is permitted in accordance with 42 CFR § 164.504(e)(2)(i)(B).

d. To the extent otherwise permitted by this Agreement, a communication that is described in the definition of Marketing in 45 CFR § 164.501 for which the Department receives or has received Direct or Indirect Payment (excluding payment for Treatment) in exchange for making such communication, shall not be considered a Health Care Operation unless:

(i) such communication describes only a drug or biologic that is currently prescribed for the recipient of the communication and any payment received in exchange for making such a communication is reasonable in amount; or

(ii) the communication is made by the Business Associate on behalf of the Department and the communication is otherwise consistent with this Agreement. No communication may be made by the Business Associate without prior written authorization by the Department.

7. Obligations of the Department

a. The Department must notify the Business Associate of any limitation(s) in the Department's notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of PHI. A copy of the Department's Notice of Privacy Practice is attached to this Agreement and incorporated herein.

b. The Department must notify the Business Associate of any changes in, or revocation of, permission by a person to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

c. The Department must notify the Business Associate of any restriction to the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. The Department, except as may be expressly agreed to by the parties and stated in this Agreement, may not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the requirements of the HIPAA and HITECH Acts and the implementing regulations if done by the Department.

8. Term and Termination

a. The term of this Agreement shall be effective as of the effective date that the Business Associate begins delivery of its services and shall terminate when all of the PHI provided by the Department to the Business Associate, or created or received by the Business Associate on behalf of the Department, is destroyed or returned to the Department, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this subsection.

b. Upon the Department's knowledge of a breach, as defined in § 164.402, by the Business Associate, the Department, as its sole discretion, must provide an opportunity for the Business Associate to:

(i) cure the breach; or
(ii) end the violation and terminate this Agreement if the Business Associate does not cure the breach; or
(iii) end the violation within the time specified by the Department; or
(iv) immediately terminate this Agreement if the Business Associate has breached a material term of this Agreement and cure is not possible; or
(v) if neither termination nor cure are feasible, the Department must report the violation to the Secretary.

c. Upon the Business Associate's knowledge of a material breach by the Department, the Business Associate must either:

(i) notify the Department of such breach in reasonable detail, and provide an opportunity for the Department to cure the breach or violation; or
(ii) if cure is not possible, the Business Associate may immediately terminate this Agreement; or
(iii) if neither termination nor cure is feasible, the Business Associate shall repot the violation to the Secretary.

d. The Department may unilaterally terminate this Agreement with the Business Associate upon thirty (30) days written notice in the event:

(i) the Business Associate does not promptly enter into negotiations to amend this Agreement when requested by the Department pursuant to the terms of this Agreement; or
(ii) the Business Associate does not enter into an amendment to this Agreement providing assurance regarding the safeguarding of PHI that the Department, in its sole discretion, deems sufficient to satisfy the standards and requirements of the HIPAA and HITECH Acts and the implementing regulations.

9. Effect of Termination

a. Except as provided in this subsection, upon termination of this Agreement, for any reason, the Business Associate shall at the Department's sole discretion return or destroy all PHI received from the Department or created or received by Business Associate on behalf of the Department. This Agreement shall apply to PHI that is in the possession of subcontractors or agents of the Business Associate. The Business Associate shall retain no copies of the PHI.

b. In the event that the Business Associate determines that returning or destroying the PHI is infeasible, the Business Associate must provide to the Department notification of the conditions that make return or destruction infeasible. Upon written agreement by the Department that return or destruction of PHI is infeasible, the Business Associate must extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains such PHI.

10. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Regulation or Security Regulation means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Department to comply with the requirements of the HIPAA and HITECH Acts and the implementing regulations.

c. Survival. The respective rights and obligations of the Business Associate under this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Department to comply with the requirements of the HIPAA and HITECH Acts and the implementing regulations.

The Contractor assures the Department:

GENERAL COMPLIANCE REQUIREMENTS

H. That the Contractor is in compliance with those provisions of the privacy, security, electronic transmission, coding and other requirements of the federal Health Insurance Portability And Accountability Act of 1996 (HIPAA) and the federal Health Information Technology For Economic And Clinical Health (HITECH), a part of the American Recovery And Reinvestment Act Of 2009, and the implementing federal regulations for both acts that are applicable to contractual performance if the Contractor is either a Covered Entity or a Business Associate as defined for purposes of those acts.

DPHHS GS-302
Rev. 06/2018

SOURCES OF INFORMATION ON THE PRIVACY, TRANSACTIONS AND SECURITY REQUIREMENTS PERTAINING TO HEALTH CARE INFORMATION OF THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND THE FEDERAL HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH), ENACTED AS PART OF THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

The following are sources of information concerning the applicability of and implementation of the privacy, transactions and security requirements of HIPAA and HITECH. The Department Of Public Health & Human Services requires that contractors generating, maintaining, and using health care information in relation to recipients of State administered and funded services be compliant with the requirements of HIPAA and HITECH as applicable under the federal legal authorities and the status of the Department as a health care plan.

There can be difficulty in interpreting the applicability of the HIPAA and HITECH requirements to an entity and various circumstances. It is advisable to retain knowledgeable experts to advise concerning determinations of applicability and appropriate compliance.

Websites specified here may be changed without notice by those parties maintaining them.

FEDERAL RESOURCES

The following are official federal resources in relation to HIPAA and HITECH requirements. These are public sites. Implementation of the additional requirements under HITECH, due to the more recent date of enactment, is occurring on an ongoing basis.

1) U.S. Department Of Health & Human Services / Office Of Civil Rights www.hhs.gov/ocr/hipaa

The federal Department of Health & Human Services / Office of Civil Rights (OCR) provides information pertaining to privacy and security requirements under HIPAA and HITECH including the adopted regulations and various official interpretative materials. This site includes an inquiry service. OCR is responsible for the implementation of the privacy and security aspects of HIPAA/HITECH and serves as both the official interpreter for and enforcer of the privacy requirements.

2) U.S. Department of Health & Human Services / Centers for Disease Control & Prevention
http://www.cdc.gov/Other/privacy.html

The federal Department of Health & Human Services / Centers for Disease Control & Prevention (CDC) provides information pertaining to the application of privacy requirements under HIPAA to public health activities and programs.

STATE RESOURCES

The Department Website for Medicaid Provider Information provides general information for providers of services on compliance with various state and federal requirements. https://medicaidprovider.mt.gov/

Further information concerning HIPAA/HITECH compliance in the delivery of services funded through the Department's various programs can be reviewed at the Department Website for DPHHS HIPAA Policies.
https://dphhs.mt.gov/HIPAA

Certain departmental programs may have more detailed guidance available in relation to particular programs of services. Inquiries may be directed at a program to determine if further information is available.

PROVIDER ASSOCIATIONS

Many national and state provider associations have developed extensive resources for their memberships concerning HIPAA/HITECH requirements. Those are important resources in making determinations as to the applicability and implementation of HIPAA/HITECH.

CONSULTANT RESOURCES

There are innumerable consulting resources available nationally. The Department does not make recommendations or referrals as to such resources. It is advisable to pursue references before retaining any consulting resource. Some consulting resources may be inappropriate for certain types of entities and circumstances.

CONTRACT NUMBER Insert Contract Number

THIS CONTRACT, is entered into between the Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division (the "Department"), whose contact information is as follows: 100 N. Park, Suite 300, Helena, MT, 59620-2905, and Phone Number (406) 444-3964, and Fax Number (406) 444-9389, and Insert Contractor Name (the "Contractor"), whose contact information is as follows: Federal Tax ID Insert Federal Tax ID Number, Insert Street Address, Insert City, Insert State, Insert Zip Code, Phone Number Insert Phone Number, and Fax Number Insert Fax Number; respectively (collectively, the "Parties").

RECITALS

Therefore, in consideration of the foregoing recitals, covenants, terms and conditions set forth herein, the Parties agree as follows:

SECTION 1. SERVICES/SCOPE OF WORK

A. This Contract constitutes the basic agreement between the parties for: The purchase of community based substance use disorder and co-occurring treatment services for people with a diagnosed substance use disorder and who are current residents of the State of Montana.

B. Time is of the essence under this Contract.

C. The Department and the Contractor, their employees, agents, contractors and subcontractors will cooperate with each other, and with other state or federal administrative agency employees, contractors and subcontractors at no charge for purposes relating to the delivery of and administration of the services to be delivered under this Contract.

D. The Contractor will perform the Services in accordance with all of the provisions of the Contract, which consists of the following documents:

1. Contract (this instrument)
2. Attachment A: Scope of Work
3. Attachment B: Payment Schedule / Requirements
4. Attachment C: Certified Behavioral Health Peer Support
5. Attachment D: School-Based Services [HS1]
6. Attachment E: Assurance Of Compliance With Certain Requirements For Substance Use Disorders Treatment Service Contractors
7. Attachment F: Invoice Forms
8. Attachment G: Federal and State Law Requirements
9. Attachment H: Insurance Requirements
10. Attachment I: Business Associate Agreement
11. Attachment J: Assurances
12. Attachment K: Dark Money Disclosure Declaration [HS2]

SECTION 2. TERM OF CONTRACT

The term of this Contract is from October 1, 2019, through September 30, 2020, unless terminated in accordance with the Contract. Renewals of this Contract, by written agreement of the parties, may be made at one-year intervals, or any interval that is agreed upon by both parties. The Contract may not be renewed for more than a total of seven years.

SECTION 3. CONSIDERATION AND PAYMENTS

Subject to the terms and conditions contained in this Contract, the Department will pay the Contractor for the Services as follows:

A. Total Reimbursement Available

The total reimbursement provided to the Contractor for the purposes of this Contract may not exceed $_____ for the period the Contract is in effect and the Contractor is eligible to receive contract funds.

B. Other Programs as Payers for Services – Non-Duplication of Payment

1. The Contractor may not seek compensation from monies payable through this Contract for the costs of goods and services that may be or are reimbursed, in whole or in part, from other programs and sources.

2. Clients who are eligible for Medicaid must be enrolled and if eligibility is approved, all Medicaid covered services must be billed to Medicaid. Only approved services not covered by Medicaid up to 200% of the Federal Poverty Level can be reimbursed by funds in this Contract.

3. The Contractor must seek reimbursement from all Medicaid, insurance, or other third party payer reimbursement opportunities for payment of services purchased under this Contract prior to seeking reimbursement from this contract.

4. Lack of provider enrollment or failure to properly submit claims to third party payer does not constitute denial of payment for the ability to bill this Contract.

5. The Contractor and licensed clinical staff must be enrolled as current Medicaid providers under the terms of this Contract.

6. Costs for treatment services provided to clients who refuse to enroll in Medicaid or other available health insurance programs are the responsibility of the client and cannot be billed to this Contract.

C. Billing Procedures and Requirements

1. Payment pursuant to the billing requirements as referenced in Attachment B.

2. Payment to the Contractor shall be made to:

Insert Contractor Name
Insert Address
Insert City, Insert State, Insert Zip Code

3. The Contractor must bill in accordance with the procedures and requirements the Department identifies and must itemize all services and expenses for reimbursement. Contractor must submit invoices through the Substance Abuse Management System (SAMS) or on forms the Department provides. Paper forms are referenced in Attachment E.

D. Adjustments to Consideration

The Department may adjust the consideration provided to the Contractor under this Contract based on any reductions of funding, governing budget, erroneous or improper payments, audit findings, or failings in the Contractor's delivery of services.

E. Sources of Funding

The sources of the funding for this Contract are a combination of Substance Abuse Block Grant (CFDA 93.959) and state alcohol tax.

F. Erroneous and Improper Payments

The Contractor may not retain any monies the Department pays in error or which the Contractor, its employees, or its agents improperly receive. The Contractor must immediately notify the Department if it determines a payment may be erroneous or improper, and must return that payment within 30 days of the Department requesting its return. If the Contractor fails to return to the Department any erroneous or improper payment, the Department may recover such payment by any methods available under law or through this Contract, including deduction of the payment amount from any future payments to be made to the Contractor.

G. Final Payment

The Department will issue the final payment to the Contractor for the Services when the Department has accepted the Services and determined that the Contractor has met all of its Contract performance obligations satisfactorily.

SECTION 4. CREATION AND RETENTION OF RECORDS

A. The Contractor must maintain all records, (written, electronic or otherwise) documenting compliance with the requirements of this Contract and its attachments, and with state and federal law, relating to performance, monetary expenditures and finances during the term of this Contract and for 8 years after its completion date. The obligation to maintain records required by this paragraph survives the termination or expiration of this Contract.

B. If any litigation, reviews, claims or audits concerning the records related to the performance of the Contract is begun, then the Contractor must continue to retain records until such activity is completed.

C. The Contractor must provide the Department and its authorized agents with reasonable access to records the Contractor maintains for purposes of this Contract. The Contractor must make the records available at all reasonable times at the Contractor's general offices or other location as agreed to by the parties.

SECTION 5. ACCOUNTING, COST PRINCIPLES, AND AUDIT

A. Accounting Standards

1. The Contractor must maintain a system of accounting procedures and practices sufficient for the Department to determine to its satisfaction that the system (1) permits timely development of all necessary cost data in the form contemplated by the contract type, and (2) is adequate to allocate costs in accordance with Generally Accepted Accounting Principles.

2. The Contractor must comply with the audit requirements of Federal Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" and the cost and accounting principles set forth in the provisions of the applicable OMB Circular concerning the use of the funds provided under this Contract.

B. Audits and Other Investigations

The Department and any other legally authorized federal and state entities and their agents may conduct administrative activities and investigations, including audits, to ensure the appropriate administration and performance of this Contract, and the proper expenditure of monies, delivery of goods, and provision of Services pursuant to this Contract. The Contractor will provide the Department and any other authorized governmental entity and their agents access to and the right to record or copy any and all of the Contractor's records, materials and information necessary for the conduct of any administrative activity, investigation or audit. Administrative activities and investigations may be undertaken, and access shall be afforded under this section from the time the parties enter this Contract until the expiration of 8 years from the completion date of this Contract.

C. Corrective Action

If directed by the Department, the Contractor must take corrective action to resolve audit findings. The Contractor must prepare a corrective action plan detailing actions the Contractor proposes to undertake to resolve the audit findings. The Department may direct the Contractor to modify the corrective action plan.

D. Reimbursement for Sums Owing

The Contractor must reimburse or compensate the Department in any other manner as the Department may direct for any sums of monies determined by any administrative activity, investigation or audit to be owing to the Department.

E. The Contractor must comply with the federal audit and cost accounting requirements set forth in 45 CFR Part 75 and 2 CFR Part 300.

SECTION 6. ASSIGNMENT, TRANSFER, AND SUBCONTRACTING

A. The Contractor will not assign, transfer, delegate or subcontract any right or duty arising under this Contract without prior written approval from the Department.

B. Any assignment, transfer, delegation, or subcontracting of the Contractor's rights or duties under this Contract does not relieve the Contractor from its responsibility and liability for performance of all Contractor obligations under this Contract. The Contractor will be as fully responsible for the acts or omissions of any subcontractor as it is for its own acts or omissions.

SECTION 7. INDEMNIFICATION

A. The Contractor, at its sole cost and expense, must indemnify, defend, and hold harmless the State of Montana against any allegations of liability of any kind, relating to personal injury, death, damage to property, or any other legal obligation and any resulting judgments, losses, damages, liability, penalties, costs, fees, cost of legal defense and attorney's fees, to the extent caused by or arising out of Contractor's performance of services under this Contract or in any way resulting from the acts or omission of Contractor, and/or its agents, employees, representatives, assigns, and subcontractors.

B. The Department must give the Contractor notice of any allegation of liability and at the Contractor's expense the Department shall cooperate in the defense of the matter.

C. If the Contractor fails to fulfill its obligations as the indemnitor under this section, the Department may undertake its own defense. If the Department undertakes its own defense, the Contractor must reimburse the Department for any and all costs to the Department resulting from settlements, judgments, losses, damages, liabilities, and penalties and for all the costs of defense incurred by the Department including but not limited to attorney fees, investigation, discovery, experts, and court costs.

SECTION 8. LIMITATIONS OF STATE LIABILITY

A. Any liabilities of the State of Montana and its officials, employees and agents are governed and limited by the provisions of Title 2, Chapter 9, MCA, for all acts, omissions, negligence, or alleged acts or omissions, negligent conduct, and alleged negligent conduct related to this Contract.

B. The Department shall not be liable, regardless of the form of action, whether in contract, tort, negligence, strict liability or by statute or otherwise, for any claim related to or arising under this Contract for consequential, incidental, indirect, special, or exemplary damages, including without limitation lost profits and lost business opportunities.

SECTION 9. INSURANCE COVERAGE

A. Without limiting any of Contractor's obligations hereunder, Contractor must carry insurance coverage in accordance with the requirements stated in Attachment H, Insurance Requirements, attached hereto and incorporated herein by reference.

SECTION 10. CONFLICTS OF INTEREST

A. The Contractor must not have any conflict of interest regarding the performance of the Services under this Contract. The Contractor may not enter into any contract or other arrangement for the use, purchase, sale lease or rental of real property, personal property or services funded with monies of this Contract if an employee, administrator, officer or director of the Contractor may receive a financial or other valuable benefit as a result. The Department may grant exceptions to this prohibition where it determines the particular circumstances warrant the granting of an exception.

SECTION 11. COMPLIANCE WITH LAWS/WARRANTIES

A. The Contractor must comply with all state and federal laws, rules, regulations, ordinances, and executive orders applicable to the performance of the Services under this Contract. Attachment G to this Contract contains a list of state and federal authorities. The Contractor must assure that all subcontractors comply with all applicable laws.

B. Civil Rights. The Contractor may not discriminate in any manner against any person on the basis of race, color, national origin, age, physical or mental disability, marital status, religion, creed, sex, sexual orientation, political beliefs, genetic information, veteran's status, culture, social origin or condition, ancestry, or an individual's association with individuals in any of the previously mentioned protected classes in the performance of this Contract or in the delivery of Montana State services or funding on behalf of the State of Montana.

C. The Contractor must submit the assurances, where applicable, set forth in Attachment G and attached as Attachment J, to this Contract prior to commencement of work under this Contract.

D. The Contractor represents and warrants that the Contractor is legally authorized under state and federal business and tax legal authorities to conduct business in accordance with this Contract.

E. The Contractor represents and warrants that it is an independent contractor and that its employees, agents and subcontractors are not employees of the State of Montana. The Contractor may not in any manner represent or maintain the appearance of being employees of the State of Montana.

F. The Contractor must comply with all applicable Workers' Compensation requirements.

G. The Contractor must pay all state, federal, social security, unemployment insurance, and all other taxes, assessments, or contributions due and payable to the State of Montana and/or the United States in connection with the Services to be performed under this Contract. The Contractor must hold the State of Montana harmless from any liability on account of any such taxes or assessments.

SECTION 12. REGISTRATION OF OUT OF STATE ENTITIES

A. Any business intending to transact business in Montana must register with the Secretary of State. Businesses that are domiciled in another state or country, but which are conducting activity in Montana, must determine whether they are transacting business in Montana in accordance with 35-1-1026 and 35-8-1001, MCA. Such businesses may want to obtain the guidance of their attorney or accountant to determine whether their activity is considered transacting business.

If businesses determine that they are transacting business in Montana, they must register with the Secretary of State and obtain a certificate of authority to demonstrate that they are in good standing in Montana. To obtain registration materials, call the Office of the Secretary of State at (406) 444-3665, or visit their website at http://sos.mt.gov.

SECTION 13. OWNERSHIP OF DATA AND DOCUMENTS

A. All data, information, work in progress, documents, reports, patents or copyrights developed in connection with any services under this Contract or information provided to the Contractor, both in hard-copy form and as may be embodied on any recording and storage media, is deemed Department property and, upon request at the termination or expiration of this Contract, shall be delivered to the Department.

SECTION 14. CONFIDENTIALITY

A. Personal Information

1. During the term of this Contract, the Contractor, its employees, subcontractors and agents must treat and protect as confidential all material and information the Department provides to the Contractor or which the Contractor acquires on behalf of the Department in the performance of this Contract which contains the personal information of any person.

2. In its use and possession of personal information, the Contractor must conform to security standards and procedures meeting or exceeding current best business practices. Upon the Department's request, the Contractor will allow the Department to review and approve any specific security standards and procedures of the Contractor.

B. Notice by Contractor of Unauthorized Disclosures or Uses of Personal Information

1. Immediately upon discovering any unauthorized disclosure or use of personal information by the Contractor, its employees, subcontractors, agents, the Contractor must confidentially report the disclosure or use to the Department in detail, and must undertake immediate measures to retrieve all such personal information and to prevent further unauthorized disclosure or use of personal information.

C. Notice by Contractor of Investigations, Complaints, Litigation Concerning the Use and Protection of Personal Information

1. The Contractor must provide the Department with written notice within five work days of the Contractor receiving notice of any administrative action or litigation threatened or initiated against the Contractor based on any legal authority related to the protection of personal information.

2. With its notice, the Contractor must provide the Department with copies of any relevant correspondence, pleadings, papers, administrative or legal complaints and determinations.

D. Contract Information

The Contractor must hold in strict confidence any data, findings, results, or recommendations obtained or developed by the Contractor in connection with the Services under this Contract, including but not limited to, information and data given to the Contractor by the Department, its agents or contractors or any other source.

E. Access/Use of Confidential Information

The Contractor may not access or use personal, confidential, or other information obtained through the Department, its agents and contractors, unless the Contractor does so:

1. in conformity with governing legal authorities and policies;

2. with the permission of the persons or entities to whom or which the information pertains; and

3. with the review and approval by the Department prior to use, publication or release.

F. The information contained within this Contract and attachments, inclusive of Contractor's proposal and its attachments, if any, and information otherwise provided to the Department in relation to this contractual relationship is not confidential and is available for public inspection and copying unless determined in accordance with federal or state law to be confidential as personal consumer, recipient or employee information or as business/corporate proprietary information that is protected from release. To any extent required or allowed by law, the Department has the right to use for public purposes and to disclose to the public contractual information inclusive of reports, evaluations, statistics, and other management and performance information related to this Contract.

SECTION 15. PROPRIETARY INFORMATION

A. Before the Department can recognize a business/corporate claim of confidential trade secret or proprietary information, the Contractor must identify and segregate the information for which the claim is being asserted and must have provided a detailed legal analysis supporting the claim of confidentiality. The Contractor must include with that claim an affidavit of legal counsel on the form provided by the Department, titled "AFFIDAVIT FOR PROPRIETARY INFORMATION CONFIDENTIALITY," attesting to legal counsel's legal relationship to the Contractor, acknowledging the primacy of federal and Montana law with respect to the claim, and indemnifying the Department with respect to defense and warranting the Contractor's responsibility for all legal costs and attorneys' fees, should the Department accept the claim as legitimate and as a result be subjected to administrative or legal contest.

B. The Department will provide the Contractor timely notice of any administrative or legal request or contest from a third party seeking release of contractual and related information for which the Contractor has properly made a claim that the information is confidential as trade secret or proprietary information. If the Department determines that such information is subject to the public right to know and must be released as requested, the Department will provide the Contractor with notice of the intended release five working days prior to the date of the proposed release. The notice period is intended to allow the Contractor to make arrangements, if desired, to intervene through an appropriate legal forum to contest the release.

SECTION 16. COMPLIANCE WITH THE FEDERAL HIPAA AND HITECH PRIVACY AND SECURITY REQUIREMENTS

A. If the Contractor is a "Business Associate" as defined at 45 C.F.R. § 160.103, it must comply with the privacy and security requirements for functioning as a "business associate" of the Department or as a "covered entity" under HIPAA and HITECH. In addition to executing this Contract, the Contractor must execute the Business Associate Agreement attached to this Contract as Attachment I.

SECTION 17. PUBLICITY AND DISCLAIMERS

A. The Contractor may not use monies under this Contract to pay for media, publicity or advertising that in any way associates the services or performance of the Contractor or the Department under this Contract with any specific political agenda, political party candidate for public office, or any matter to be voted upon by the public. Media includes but is not limited to commercial and noncommercial print, verbal and electronic media.

B. The Contractor must inform any people to whom it provides consultation or training services under this Contract that any opinions expressed do not necessarily represent the position of the Department. All public notices, information pamphlets, press releases, research reports, posters, public service announcements, web sites and similar modes of

presenting public information pertaining to the services and activities funded with this Contract prepared and released by the Contractor must include the statement:

> "This project is funded in whole or in part under a Contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department."

C. The Contractor must state the percentage and the monetary amount of the total program or project costs of this Contract funded with (a) federal monies and (b) non-federal monies in all statements, press releases, and other documents or media pieces made available to the public describing the services provided through this Contract.

D. Before the Contractor uses, publishes, releases or distributes them to the public or to local and state programs, the Department must review and approve all products, materials, documents, publications, press releases and media pieces (in any form, including electronic) the Contractor or its agents produce with contract monies to describe and promote services provided through this Contract.

SECTION 18. ACCESS TO PREMISES

A. The Contractor must provide the State of Montana and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the Contractor's premises or other places where contractual performance occurs to inspect, monitor or otherwise evaluate contractual performance. The Contractor must provide reasonable facilities and assistance for the safety and convenience of the persons performing these duties. All inspection, monitoring and evaluation must be performed in such a manner as not to unduly interfere with contractual performance.

SECTION 19. LIAISON AND SERVICE OF NOTICES

A. Curt Weiler, Phone Number (406) 444-7926, Fax Number (406) 444-9389, and cweiler@mt.gov, or their successor, is the liaison for the Department. Insert Contractor Liaison Name, Phone Number Insert Phone Number, Fax Number Insert Fax Number, Insert Email is the liaison for the Contractor. These persons serve as the primary contacts between the parties regarding the performance of this Contract. Written notices, reports and other information required to be exchanged between the parties must be directed to the liaison at the parties' addresses set out in this Contract.

SECTION 20. FORCE MAJEURE

A. If the Contractor or the Department is delayed, hindered, or prevented from performing any act required under this Contract by an occurrence beyond the control of the asserting party including, but not limited to, theft, fire, or public enemy, severe and unusual weather conditions, injunction, riot, strikes, lockouts, insurrection, war, or court order and the asserting party gives prompt written notice of the event to the other party, then performance of the act shall be excused for the period of the delay, to the extent the performance is actually affected and the asserting party resumes performance as soon as practicable. Matters of the Contractor's finances shall not be considered a force majeure.

SECTION 21. CONTRACT TERMINATION

A. The Department may terminate this Contract without cause and in lieu of any or all other remedial measures available through this Contract. The Department terminating without cause must give written notice of termination to the Contractor at least sixty (60) days prior to the effective date of termination. In the event of such termination without cause, the Contractor shall be paid for all Services rendered satisfactorily to the termination date and for any direct costs (not including anticipated profits) incurred by the Contractor as a result of the termination. Such payment shall constitute the Contractor's sole right and remedy. The Department has the right to terminate without cause even when a condition of force majeure exists.

B. The Department may immediately terminate this Contract if the Contractor engages in any violation of state or federal law listed in this Contract or any Attachment to this Contract, or which otherwise may be applicable to the Contract arising from the performance of Services under this Contract.

C. The Department may terminate this Contract in whole or in any aspect of performance under this Contract if:

1. federal or state funding for this Contract becomes unavailable or reduced for any reason; or

2. the Department determines that the Contractor is failing to perform in accordance with the terms of this Contract. In such event, the Department shall give Contractor written notice of breach and an opportunity to cure the breach. Contractor will correct the breach within 30 calendar days of receipt of such notice unless the cure period is otherwise specified in the written notice of breach. If the breach is not corrected timely, this Contract may be terminated immediately, in whole or in part, by written notice from the Department to Contractor. The option to terminate shall be at the sole discretion of the Department.

D. Upon expiration, termination or cancellation of this Contract, or any portion of this Contract, the Contractor must assist the Department, its agents, representatives and designees in closing out this Contract, and in providing for the orderly transfer of contract responsibilities and the continued delivery of contract services by the Department or its designee, and shall allow the Department access to the Contractor's facilities, records and materials to fulfill these requirements.

SECTION 22. ADDITIONAL REMEDIES

A. Withholding Payments

If the Contractor fails to perform the services in conformance with the requirements of this Contract, the Department has the right, with notice, to withhold any and all payments directly related to the non-compliant services. The Department may withhold any payments

due to the Contractor, without penalty or work stoppage by Contractor, until the Contractor cures performance to the satisfaction of the Department. The Contractor is not relieved of its performance obligations if any payment is withheld.

B. Reductions in Payments Due

Amounts owed to the Department by the Contractor under this Contract, including but not limited to liquidated or other damages, or claims for damages, may be deducted or set-off by Department from any money payable to Contractor pursuant to this Contract.

C. If, in the Department's reasonable judgment, a default by Contractor is not so substantial as to require termination of the entire Contract, reasonable efforts to induce the Contractor to cure the default are unavailing, the Contractor fails to cure such default within 30 calendar days of receipt of notice from the Department, and the default is capable of being cured by the Department or by another resource without unduly interfering with continued performance by the Contractor, the Department, without prejudice to any other remedy it may have, may terminate performance of the particular service that is in default and provide or procure the services reasonably necessary to cure the default. In the event of a termination for failure to perform, Department will, without limiting its other available remedies, have the right to procure the terminated services and the Contractor will be liable for: (i) the cost difference between the cost of the terminated services and the costs for the replacement services acquired from another vendor or expended by Department, and (ii) if applicable, the following administrative costs directly related to the replacement of this Contract: costs of competitive bidding, mailing, advertising and staff time costs.

D. Stop Work Order

1. The Department may, at any time, by written stop work order to the Contractor, require the Contractor to stop any or all parts of the work required by this Contract for the period of days indicated by the Department after the stop work order is delivered to Contractor. The stop work order must be specifically identified as a stop work order issued under this section. Upon receipt of the stop work order, the Contractor must immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the stop work order during the period of work stoppage.

2. If a stop work order issued under this section is canceled or the period of the stop work order, or any extension expires, the Contractor must resume contractual performance. The Department, as may be necessary, must adjust through amendment to this Contract the delivery schedule or reimbursement, or both.

E. Right to Assurance

If the Department, in good faith, has reason to believe that the Contractor does not intend to, or is unable to perform or has refused to perform or continue performing all material obligations under this Contract, the Department may demand in writing that the Contractor give a written assurance of intent to perform. Failure by Contractor to provide written assurance within the number of days specified in the demand (not less than five business days) may, at the Department's option, be the basis for terminating this Contract under the

terms and conditions or other rights and remedies available by law or provided by this Contract.

F. Any remedies provided by this Contract are not exclusive and are in addition to any other remedies provided by law.

SECTION 23. CHOICE OF LAW, REMEDIES AND VENUE

A. This Contract is governed by the laws of the State of Montana.

B. For purposes of litigation concerning this Contract, venue must be in the First Judicial District in and for the County of Lewis and Clark, State of Montana.

C. If there is litigation concerning this Contract, the Contractor must pay its own costs and attorney fees.

SECTION 24. GENERAL

A. No statements, promises, or inducements made by the parties or their agents are valid or binding if not contained in this Contract and the materials expressly referenced in this Contract as governing the contractual relationship.

B. The headings to the section of this Contract are convenience of reference and do not modify the terms and language of the sections to which they are headings.

C. Except as may be otherwise provided by its terms, this Contract may not be enlarged, modified or altered except by written amendment signed by the parties to this Contract.

D. If there is a dispute as to the duties and responsibilities of the parties under this Contract, this Contract along with any attachments prepared by the Department, including request for proposal, if any, govern over the Contractor's proposal, if any.

E. If a court of law determines any provision of this Contract is illegal, all other provisions of this Contract remain in effect and are valid and binding on the parties.

F. Any provision of this Contract that is determined to conflict with any federal or state law or regulation, is inoperative to the extent it conflicts with that authority and is to be considered modified to the extent necessary to conform with that authority.

G. Waiver of any default, breach or failure to perform under this Contract may not be construed to be a waiver of any subsequent default, breach or failure of performance. In addition, waiver of a default, breach or failure to perform may not be construed to be a modification of the terms of this Contract unless reduced to writing as an amendment to this Contract.

H. This Contract may be executed in counterparts, which together will constitute one instrument.

The parties through their authorized agents have executed this Contract on the dates set out below.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

BY: _____ Date: _____
Insert Name, Insert Title

CONTRACTOR

BY: _____ Date: _____
Insert Name, Insert Title

ATTACHMENT A To Contract No. Insert Contract Number

SCOPE OF WORK

I. ACRONYMNS

A. The following acronyms are applicable to this Contract.

ACT	Assessment, Course, and Treatment
AMDD	Addictive and Mental Disorders Division
ARM	Administrative Rules of Montana
ASAM	American Society of Addiction Medicine
DSM	Diagnostic Statistical Manual
ICD	International Classification of Diseases
MAT	Medication Assisted Treatment
MCA	Montana Code Annotated
SAMS	Substance Abuse Management System
SABG	Substance Abuse Block Grant
SUD	Substance Use Disorders

II. SCOPE OF WORK

A. For services purchased under this Contract, the Contractor must:

1. perform services in compliance with the most current version of the:
   a. Montana Code Annotated (MCA);
   b. Administrative Rules of Montana (ARM);
   c. Non-Medicaid Manual
   d. American Society of Addiction Medicine (ASAM); and
   e. Diagnostic Statistical Manual (DSM) and ICD (International Classification of Diseases) diagnosis manual.

2. maintain State Approved Chemical Dependency Provider status as required by the MCA and ARM.

3. maintain a current Health Facility License as required by ARM 37.106.1411 through 37.106.1491 for residential and inpatient treatment facilities.

B. For services purchased under this Contract, the Contractor must provide a continuum of treatment services as defined in the ASAM and the non-Medicaid manual, or as outlined below. Treatment[HS3] services are limited to following:

1. Adult and adolescent outpatient services.

2. Certified Behavioral Health Peer Support (BHPS) - Group Adult:
   a. see Medicaid and non-Medicaid for requirements for individual peer support services.
   b. see Attachment B for requirements.

3. School-based services:
   a. are provided in the school setting unless requested by the student to have an alternative setting.

   b. The Department must approve the SBS Program before services can be reimbursed. The Contractor will submit a current school-based service and evaluation plan which includes:

      - The name and curriculum for the evidence-based program to be implemented, with a fidelity tool if available;
      - Projected number of students to be served;
      - Staffing (including hours of service and days of the week);
      - Specific services to be provided (i.e. education, screenings, brief interventions, other activities, etc.); and
      - The referral process and coordination with other programs.
      - Submit a copy of a Memorandum of Understanding (MOU) with the school(s) where the SBS will be implemented.

   c. The Contractor will collect and submit SBS evaluation data to the Department Liaison by the 10th working day of the month following the month services were provided. Criteria for reporting is outlined in Attachment D.

4. Co-occurring services:
   a. are provided to individuals who have a diagnosed substance use disorder and an identified mental health diagnosis.

   b. are provided directly by the Contractor or through a written agreement with qualified licensed mental health professional(s). Written agreements must be available upon request by the Department.

   c. are provided by an interdisciplinary team where licensed mental health professional(s) providing mental health services actively participate in developing integrated treatment plans and case consultation for the client with a co-occurring diagnoses.

   d. include appropriate psychiatric evaluations, pharmacological management and medication are provided as clinically necessary and are reimbursable under this Contract when all other options for payment are not available.

   e. include co-occurring medication reimbursement under this Contract and is limited to only necessary psychotropic drugs prescribed by an appropriately licensed professional.

5. Clinically managed low-intensity residential treatment (ASAM level of care 3.1):

a. is provided at the following facilities:

Facility Name	M/F	Target Population

6. Medicated Assisted Treatment: Refer to the *Non-Medicaid Manual* and the *AMDD Medicaid Provider Services Manual* for requirements for Medicated Assisted Treatment.

C. Other Provisions

1. Travel:
   a. is limited to mileage only and may only be invoiced by the Contractor.

   b. is used only for travel in the following situations:

      i. from the Contractor's main facility to Contractor's satellite facilities for providing treatment or supervision services as outlined in this Contract.
      ii. from the Contractor's main facility or satellite facility to alternative treatment settings to provide services covered under this contract.
      iii. from the Contractor's main facility or satellite facility to Department sponsored training events.

   c. is reimbursed at the current federal mileage reimbursement rates found at www.gsa.gov.

2. Training Events:
   a. Must be approved by the Department prior to implementation. Contractor will provide a description of the training, an implementation and reporting plan, and a detailed training budget to the Department Liaison.

   b. Must be evidence based.

   c. Must be opened to other State approved providers if class capacity is available.

   d. Do not include state sponsored or out-of-state training expenses for the Contractor's employees.

3. Special Projects.

III. REPORTING AND DOCUMENTATION REQUIREMENTS

A. For services rendered through this Contract, the Contractor will:

1. require staff responsible for entering data into SAMS, to attend Department training prior to accessing the SAMS database.

2. enter client and service data to be paid under this Contract into the SAMS within 7 days of providing services.

3. enter all data into the SAMS for the Assessment, Course and Treatment program.

4 participate and submit client satisfaction survey information.

5. provide written documentation to the client and/or caregiver if a client is denied services at any time. Documentation must include reason(s) why the denial of services and provide the client with the process for the right to appeal within 5 working days of the denial of services.

ATTACHMENT B To Contract No. Insert Contract Number

PAYMENT SCHEDULE / BILLING REQUIREMENTS

1. Contract funding is allocated as follows:

   Oct 1, 2019 thru Sept 30, 2020, Alcohol Tax
   Oct 1, 2019 thru Sept 30, 2020, SAPT BG

2. Treatment services under this Contract are reimbursed by procedure code listed on the non-Medicaid Schedule, located on the AMDD website:

   http://dphhs.mt.gov/amdd/SubstanceAbuse.aspx

3. Invoices for reimbursement of all services must be submitted through SAMS, or on the appropriate paper invoice, by the 10th working day of each month following the month the service was provided. Invoices and forms not provided through SAMS may be found in Attachment F to this Contract.

   a. The Contractor must invoice the Department for outpatient, intensive outpatient, co-occurring, low-intensity residential treatment services (3.1) using the invoices available in the SAMS system.

   b. Paper invoices and forms must reference the contract number, be signed and dated by the program, and submitted to the Department Liaison, or their designee, by the 10th working day of the month following the month services were provided.

4. Payment for questioned costs may be withheld pending resolution of the disputed costs and may require rebilling by the Contractor.

5. The Contractor must submit all final claims and corrected invoices for the preceding fiscal year by November 30th.

6. If the Contractor finds it necessary to submit a corrected invoice for services from the prior fiscal year, the corrected invoice must be received by the Department before October 31st of the current fiscal year. Corrected invoices for more than one prior fiscal year may not be paid.

7. It is expected that by March 1 of each year, the Contractor will have expended up to, or more than, 50% of their current fiscal year contract funding for services provided October 1st through March 31st. By April 30th, the Department will review spending, and based on submitted and paid invoices, may consider adjusting the funding to reflect projected spending through the remainder of the Contract term.

   a. Contractors who have spent 50% or more of their current fiscal year funding by March 30th may request additional funds. Requests must be submitted to the Department in writing by May 31st. Additional funds will only be approved if the Contractor has completed all reporting and documentation requirements found in Section 5.D., and if funds are available.

b. Contractors who have spent 50% or less of their current fiscal year funding by March 30th may submit to the Department by May 31st, an Action Plan indicating their intent to spend down funds.

ATTACHMENT C To Contract No. Insert Contract Number

Certified Behavioral Health Peer Support (BHPS) - Group Adult

Definition:
Certified Behavioral Health Group Peer Support is a face-to-face service provided in a group setting of up to eight individuals to promote positive coping skills through a department approved curriculum. The purpose is to help members through a process of change to improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Provider Requirements:
(1) BHPS-Group must be provided by a Certified Behavioral Health Peer Support Specialist (BHPSS), certified by the Montana Board of Behavioral Health (BHH); and provided and billed by a state approved program under contract with the Department.
(2) The state-approved program must:
(a) ensure staff are certified by the BBH;
(b) develop policies and procedures for initial and on-going staff training for these services;
(c) assure ongoing communication and coordination of the treatment team to ensure the services provided are updated as needed; and
(d) establish the frequency of services as determined by needs of the member.

Medical Necessity Criteria:
Member must meet the SUD criteria as described in the most recent version of the AMDD Medicaid Services Provider Manual for SUD and Adult Mental Health which can be found on the AMDD webpage at: https://dphhs.mt.gov/amdd.

Prior Authorization: Prior Authorization is not required.

Service Requirements:
(1) BHPS-Group must be a direct service provided in a group setting.
(2) The maximum BHPS-Group size is eight individuals.
(3) BHPS-Group is limited to 8 units per week per member.
(4) Must utilize one of the following evidence-based or research-based curriculums:
a. Self-Management and Recovery Training (SMART);
b. Interactive Journaling: “My Personal Health Journal” or ”Wellness and Recovery”;
c. Healthy Minds Healthy Bodies;
d. Wellness Recovery Action Plan (WRAP);
e. Whole Health Action Management (WHAM);
f. Peer to Peer (P2P); or
g. A provider may submit other curriculums not listed above, with the supporting research or documentation of appropriateness of the program, for consideration and approval by the department.

The above curriculum’s may be modified to meet national Culturally Linguistically Appropriate Services (CLAS) standards. Please notify the department prior to implementation of any modified curriculum.
(5) The Individual Treatment Plan (ITP) must include peer support goals that address the individual’s primary behavioral health needs;
(6) BHPS-Group must be billed using the appropriate HCPCS code;
(7) BHPS includes the following components:
(a) coaching to restore skills;
(b) self-advocacy support;
(c) crisis/relapse support;
(d) facilitating the use of community resources; and

(e) restoring and facilitating natural supports and socialization.

(8) Medically necessary services must be provided and documented in the treatment plan and the services received must be documented clearly in the member's treatment file.

(9) BHPS-Group services must be delivered by a dedicated BHPS whose primary responsibility is the delivery of BHPS services.

Continued Stay Review: Not applicable.

Continued Stay Criteria: Not applicable

UR Required Forms: Not applicable.

SABG Prevention / Early Intervention Services

School-Based Services

School-Based Services (SBS) are evidenced-based primary prevention/early intervention programs to prevent or reduce youth substance use. SBS are not therapy services, rather services designed to address problems or risk factors related to substance use consequences and are intended to promote protective factors and provide skills development.

These services are limited to the following evidence based programs and provided by staff who have received training in the model:

- LifeSkills Training®
- Project Towards No Drug Use®
- Team Intervene®
- State-wide Indian Drug Prevention Program®.

Other SBS primary prevention/early intervention programs will be considered on a case-by-case basis with the submission of a detailed service plan, documentation of research, and evaluation plan for program implementation.

Programs that receive SBS funding must:

1. Have on file, a current school-based service and evaluation plan which includes:

- The name and curriculum for the evidence-based program to be implemented, with a fidelity tool if available;
- Projected number of students to be served;
- Staffing (including hours of service and days of the week);
- Specific services to be provided (i.e education, screenings, brief interventions, other activities, etc.); and
- The referral process and coordination with other programs.

2. Collect and submit evaluation data monthly to the Department. A tracking form will be provided by the Department and the following data will need to be collected:

- Unique Identifier for each student enrolled in the program;
- Student Age;
- Student Gender;
- Referral source;
- Intervention used;
- Service type;
- Number of sessions;
- Perception of risk;
- Intent to make changes; and
- Helpfulness of program.

File documentation for ALL students receiving School-Based Services. These records must be available for Quality Assurance Audits.

ATTACHMENT E To Contract No. Insert Contract Number

ASSURANCE OF COMPLIANCE WITH CERTAIN REQUIREMENTS FOR SUBSTANCE USE DISORDERS TREATMENT SERVICE CONTRACTORS (July 2008)

On behalf of _____, in relation to the performance of services under the proposed contract, I certify to the Department the following:

Pregnant Women and Women with Dependent Children

1. The program treats the family as a unit and, therefore, admits both women and their Children into treatment services, if appropriate.

2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care.

3. The program provides or arranges for child care while the women are receiving services.

4. The program provides or arranges for primary pediatric care for the women's children, including immunizations.

5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.

6. The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

7. The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (2.) Through (6.) above.

Capacity of Treatment for Intravenous Drug Abuser:

If the program treats individuals for intravenous substance abuse, the program must adhere to items (8) through (15).

8. Within 7 days of reaching 90 percent of its treatment capacity, the program notifies the State that 90 percent of the capacity has been reached.

9. The program admits each individual who requests and is in need of treatment for intravenous drug abuse not later than:

    a. 14 days after making the request or
    b. 120 days if the program has no capacity to admit the individual on the date of the request and, within 48 hours after the request, the program makes interim services available until the individual is admitted to a substance abuse treatment program.

10. When applicable, the program offers interim services that include, at a minimum, the following:

    a. Counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
    b. Provides an at risk assessment and referral for HIV or TB treatment services, if necessary, and assures proper reporting of any active cases.

c. Follow health care recommendations for treatment active individuals and protection of others from disease transmission.
d. Counseling on the effects of alcohol and other drug use on the fetus for pregnant women and referrals for prenatal care for pregnant women.

11. The program has established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.

12. The program has a mechanism that enables it to:

a. Maintain contact with individuals awaiting admission
b. Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area.

13. The program takes clients awaiting treatment for intravenous substance abuse off the waiting list only when one of the following conditions exists:

a. Such persons cannot be located for admission into treatment or
b. Such persons refuse treatment.

14. The program carries out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:

a. The standard intervention model as described in *The NIDA Standard intervention Model for Injection Drug Users: Intervention Manual,* National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992).
b. The health education model as described in Rhodes, F., Humfleet, G.L. Et al., *AIDS Intervention Program for Injection Drug Users: Intervention Manual*, (Feb. 1992).
c. The indigenous leader model as described in Wiebel, W., Levin, L.B., *The indigenous Leader Model: Intervention Manual*, (Feb. 1992).

15. The program ensures that outreach efforts (have procedures for):

a. Selecting, training, and supervising outreach workers.
b. Contacting, communicating, and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of Federal and State confidentiality requirements.
c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV.
d. Recommending steps that can be taken to ensure that HIV transmission does not occur.

Requirements Regarding Tuberculosis

16. The program directly, or through arrangements with other public or nonprofit private entities, routinely makes available the following TB services to each individual receiving treatment for substance abuse:

a. Counseling the individual with respect to TB
b. Screening to determine if an individual has been at risk of being infected with mycobacterium TB to determine the appropriate services for the individual.
c. Providing for or referring the individuals infected by mycobacterium TB appropriate medical evaluation and treatment and assure proper reporting of active clients.

17. For clients denied admission to the program on the basis of lack of capacity, the program refers such clients to other providers of TB services and facilitates access to those services.

18. The program has implemented the infection control procedures that are consistent with those established by the Department to prevent the transmission of TB and that address the following:

    a. Screening patients and identification of those individuals who are at high risk of becoming infected.
    b. Assure that all State reporting requirements are followed while adhering to Federal and State confidentiality requirements, including 42 CFR part 2.
    c. Case management activities to ensure that individuals receive such services.

Treatment Services for Pregnant Women

19. The program gives preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant funded treatment services. Further, the program gives preference to clients in the following order:

    a. To pregnant injecting drug users first
    b. To other pregnant substance abusers second
    c. To other injecting drug users third
    d. To all others individuals fourth

20. The program makes available interim service within 48 hours to pregnant women who cannot be admitted because of lack of capacity.

Additional Requirements

21. The program makes continuing education in treatment services available to employees who provide the services.

22. The program has in effect a system to protect patient records from inappropriate disclosure, and the system:

    a. Is in compliance with all applicable State & Federal laws and regulations, including 42 CFR part 2
    b. Includes provisions for employee education on the confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure.

23. The program does not expend SAPT Block Grant funds to provide inpatient hospital substance abuse services, except in cases when each of the following conditions are met:

    a. The individual cannot be effectively treated in a community-based, non-hospital, residential program.
    b. The daily rate of payment provided to the hospital for providing the services does not exceed the comparable daily rate provided by a community-based, non-hospital, residential treatment program.

24. The program does not expend SAPT Block Grant funds to purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.

25. The program does not expend SAPT Block Grant funds to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

26. The program does not expend SAPT Block Grant funds to provide financial assistance to any entity other than a public or nonprofit private entity.

27. The program does not expend SAPT Block Grant funds to make payments to intended recipients of health services.

28. The program does not expend SAPT Block Grant funds to provide individuals with hypodermic needles or syringes.

29. The program does not expend SAPT Block Grant funds to provide treatment services in penal or correctional institutions of the State.

30. The program uses the Block Grant as the "payment of last resort" for services for pregnant women and women with dependent children, TB services, and HIV services and, therefore, makes every reasonable effort to do the following:

    (a.) Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX; any State compensation program, and other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.
    (b.) Secure from patients or clients payments for services in accordance with their ability to pay.

31. The Program may not use funds in this Contract to pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Executive Level I of the Federal Executive Pay Scale or $186,600.00.

Strongly Encouraged Services for Women

32. The program provides pregnant women, women with dependent children, and their children, either directly or through linkages with community-based organizations, a comprehensive range of service to include:

    a. Case management to assist in establishing eligibility for public assistance programs provided by Federal, State, or local governments
    b. Employment and training programs
    c. Education and special education programs
    d. Drug-free housing for women and their children
    e. Prenatal care and other health care services
    f. Therapeutic day care for children
    g. Head Start
    h. Other early childhood programs

Not all of these assurances may be pertinent to the Contractor's circumstances. This assurance form, however, is standardized for general use and signing it is intended to encompass only provisions applicable to the circumstances of the Contractor in relation to the federal monies that are being received.

I certify, upon receipt of this Contract, to adhere to the preceding conditions and further certify that all information contained in my application/proposal for funding is true and complete to the best of my knowledge.

Signed _____ Date: _____

Insert Name, Insert Title

ATTACHMENT F To Contract No. Insert Contract Number

INVOICE FORMS

[HS4]

- Treatment Services Invoice Correction Form
- Pre-trial Treatment Services Invoice
- Peer Support Services Invoice
- Travel/Mileage Reimbursement Form
- Training Reimbursement Form
- Special Projects Request Form

These forms and the Chemical Dependency Provider Manual are also available for download on the AMDD Chemical Dependency Bureau webpage:

http://dphhs.mt.gov/amdd/SubstanceAbuse/CDProvider-ManualInvoice

Invoices, forms and the Provider Manual are updated as needed. Notification of updated materials will be provided by the Department. However, programs are encouraged to contact the Chemical Dependency Bureau if there are any questions about the forms or problems with the website.

The Chemical Dependency Bureau can be reached at (406) 444-3964.

ATTACHMENT G To Contract No. Insert Contract Number

Rev. 4/2019

FEDERAL AND STATE LAW REQUIREMENTS

A. Compliance with Federal Authorities

Contractor assures that it and any of its subcontractors will comply with all federal laws, regulations, and executive orders, that are applicable to this Contract, to include the provisions of the below referenced laws, regulations and executive orders. The list is not intended, nor must it be construed, as a listing of all federal authorities with which Contractor must comply for the purposes of the Contract, or that Contractor must comply with each of the authorities listed. The Contractor is responsible for determining with which federal authorities it must comply in the performance of the Contract.

1. Civil Rights Act of 1964 (42 U.S.C. § 2000d, *et seq*.), prohibiting discrimination based on race, color, or national origin;

2. Age Discrimination Act of 1975 (42 U.S.C. § 6101, *et seq.*), prohibiting discrimination based on age;

3. Education Amendments of 1972 (20 U.S.C. § 1681), prohibiting discrimination based upon gender;

4. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), prohibiting discrimination based upon disability;

5. Americans with Disabilities Act of 1990 (42 U.S.C. § 12101, *et seq.*), prohibiting discrimination based upon disability;

6. Vietnam-Era Veterans Readjustment Assistance Act (38 U.S.C. § 4212), prohibiting discrimination in employment against protected veterans and requiring affirmative actions of recruit and employ protected veterans.

7. The Federal Executive Orders 11246, 11478, and 11375 and 41 CRF Part 60, requiring equal employment opportunities in employment practices.

8. Executive Order No. 13166 requiring facilitation of access for persons with limited English proficiency to federally funded services.

9. False Claims Act, 31 U.S.C. §§ 3729-3733 (the “Lincoln Law”), prohibiting recipients of federal payments from submitting a false claim for payment.

10. Sherman Anti-Trust Act, 15 U.S.C. §§1-7m prohibiting any contract, trust, or conspiracy in restraint of interstate o foreign trade.

11. Anti-Kickback Act of 1986, 41 U.S.C. §§ 51-58 and the Anti-Kickback Statute, 42 U.S.C. §§ 1320(a)-(7)a, prohibiting the exchange or offer to exchange anything of value to induce the referral of federal health care program business.

12. Debarment and Suspension (Executive Orders 12549 and 12689, 2 CFR 180 and 2 CFR Subtitle B, Chapter III Part 300) prohibiting contract awards to parties listed on government-wide exclusions in the System for Award Management (SAM). SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

13. Whistleblower Protection Act, 10 U.S.C. 2409, 41 U.S.C. 4712, and 10 U.S.C. 2324, 41 U.S.C. 4304 and 4310, requiring compliance with statutory requirements for whistleblower protections.

14. Byrd Anti-Lobbying Amendment (31 U.S.C. 1352), prohibiting the use of federal funds to pay for any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant, or any other award covered by 31 U.S.C. 1352. Each tier must disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.

15. Drug-Free Workplace Act of 1988, 41 U.S.C. §701, et. seq., requiring all organizations receiving federal monies to maintain a drug-free workplace.

16. Federal Funding Accountability and Transparency Act of 2006, requiring reporting of subawards and executive compensation;

    a. First-tier Subawards.
    All recipients, unless exempt as provided in paragraph D, must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a subaward to an entity. Recipients must report the information about each obligating action in accordance with the submission instructions posted at www.fsrs.gov.

    b. Total Compensation of Recipient Executives.
        i. All recipients must report total compensation for each of the five most highly compensated executives for the preceding completed fiscal year, if,
            (A) the total Federal funding authorized to date under this award is $25,000 or more;
            in the preceding fiscal year, recipients received:
            (1) Eighty percent or more of the annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and
            (2) $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

(3) The public does not have access to information about the compensation of the executives through periodic reports filed under the Securities Exchange Act of 1934 and Internal Revenue Code of 1986.

ii. Where and when to report. Recipients must report executive total compensation described in paragraph b.1 of this award term:

(A) The Contractor is to submit the Compensation Report to the Department by the end of the month following the month in which the total of the monies obligated through this Contract is at $25,000 or more, whether occurring at the time of signing or at some later date due to a contractual amendment. The Contractor must continue to submit the Compensation Report annually during the term of the Contract on the anniversary of the initial date of submittal, even if the total consideration for the Contract is later amended to be less than $25,000.

(B) The Contractor will submit the Compensation Report to the Department by first-class mail addressed as follows or via email:
DPHHS
Attn: BFSD-FFATA Reporting
PO Box 4210
Helena, MT 59604-4210
hhsffata@mt.gov

c. Total Compensation of Subrecipient Executives.
All recipients unless exempt as provided in paragraph d. of this award term, for each first-tier subrecipient. Recipients must report the names and total compensation of each of the subrecipient's five most highly compensated executives for the subrecipient's preceding completed fiscal year, if

(i) in the subrecipient's preceding fiscal year, the subrecipient received:

(A) 80 percent or more of its annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

(B) $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and

(C) The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986.

d. Exemptions. All recipients' gross income, from all sources of the previous tax year, under $300,000, are exempt from the requirements to report:

(i) Subawards, and

(ii) The total compensation of the five most highly compensated executives of any subrecipient.

17. Disclosure of Ownership and Control Information pursuant to 42 C.F.R. §§ 455.104, 455.105, and 455.106, requiring disclosures of ownership and control, business transactions, and persons with criminal convictions in connection with the delivery of Medicaid funded services.

18. Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal Information Technology For Economic And Clinical Health of 2009 (HITECH), requiring compliance with privacy, security, electronic transmission, coding and other requirements applicable to Covered Entities or a Business Associate as defined for purposes of the acts.

19. Patient Protection and Affordable Care Act – P.L. 111-148

20. Section 1557 of the Affordable Care Act and 45 CFR Part 92, prohibiting discrimination in health programs and activities any part of which receives Federal financial assistance.

B. Compliance with State of Montana Authorities.

Contractor assures that it and any of its subcontractors will comply with all State of Montana laws, rules, ordinances and executive orders, that are applicable to this Contract, to include the provisions of the below referenced laws. The list is not intended, nor must it be construed, as a listing of all state authorities with which Contractor must comply for the purposes of the Contract, or that Contractor must comply with each of the authorities listed. Contractor is responsible for determining with which state authorities it must comply in the performance of the Contract.

1. Montana False Claims Act, Title 17, Chapter 8, part 4, MCA.

2. Montana Anti-Trust laws – §30-14-201, MCA, et. seq.

3. Montana Human Rights Act Title 49 MCA

4. Montana Governmental Code of Fair Practices Title 49, Chapter 3

C. Prohibited Use of Federal Block Grant Funds

1. Federal Grant Funds may not be used to:

a. Provide or purchase inpatient hospital services, except for SAPTBG funds may be used with exception as described in 45 CFR 96.135 (c)*.

b. Make, or to allow to be made, any cash payments to any recipients or intended recipients of health or behavioral health services.

c. Purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment.

d. Satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e. Federal funds may not be used to satisfy any condition for any State, local or other funding match requirement).

e. Provide financial assistance to any entity other than a public or nonprofit private entity.

f. To pay the annual salary of any Contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management Federal Executive Salary Schedule. This amount is currently designated for calendar year 2018 at an annual salary of $189,600.

ATTACHMENT H To Contract No. Insert Contract Number

Rev. 4/2019

INSURANCE[HS5] REQUIREMENTS

I. Insurance.

Contractor shall maintain for the duration of the Contract, at its cost and expense, insurance against claims for injuries to persons or damages to property, including contractual liability, which may arise from or in connection with the performance of the work by the Contractor, agents, employees, representatives, assigns, or subcontractors. This insurance shall cover such claims as may be caused by any negligent act or omission.

II. Primary Insurance.

Contractor's insurance coverage shall be primary insurance with respect to the Department, its officers, officials, employees, and volunteers, and shall apply separately to each project or location. Any insurance or self-insurance maintained by the Department, its officers, officials, employees, or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

III. Insurance Requirements.

Specific Requirements for Commercial General Liability: Contractor shall purchase and maintain occurrence coverage with combined single limits for bodily injury, personal injury, and property damage, of $1,000,000 per occurrence and $2,000,000 aggregate per year to cover such claims as may be caused by any act, omission, or negligence of Contractor's officers, agents, representatives, assigns, or subcontractors.

Additional Insured Status: The Department, its officers, officials, employees, and volunteers are to be covered as additional insureds; for liability arising out of activities performed by or on behalf of the Contractor, including the State of Montana's general supervision of the Contractor; products and completed operations; and premises owned, leased, occupied, or used.

Specific Requirements for Automobile Liability: The Contractor shall purchase and maintain occurrence coverage with split limits of $500,000 per person (personal injury), $1,000,000 per accident occurrence (personal injury), and $100,000 per accident occurrence (property damage), (OR combined single limits of $1,000,000 per occurrence) to cover such claims as may be caused by any act, omission, or negligence of the Contractor's officers, agents, representatives, assigns, or subcontractors.

Additional Insured Status: The Department, its officers, officials, employees, and volunteers are to be covered as additional insureds for automobiles owned, leased, hired, or borrowed by the Contractor.

IV. Deductibles and Self-Insured Retentions.

Any deductible or self-insured retention must be declared to and approved by the Department. At the request of the Department, either: 1) the insurer shall reduce or eliminate such deductibles or self-insured retentions with respect to the Department, its officers, employees, or volunteers; or 2) at its own expense, Contractor shall procure a bond guaranteeing payment of losses and related investigations, claims administration, and defense expenses. Note: The deductible/self-

insured provision does not apply to political subdivisions of the state (i.e. counties, cities, towns, and school districts) under §2-9-211, MCA.

V. Certificates of Insurance.

Insurance is to be placed with an insurer with a Best's rating of no less than A-. Note: Best's ratings do not apply to political subdivisions of the state (i.e. counties, cities, towns, and school districts) under §2-9-211, MCA. All certificates and endorsements are to be received by the Department prior to the provision of a service or purchase of a product. Contractor must notify the Department immediately, of any material change in insurance coverage, such as changes in limits, coverages, change in status of policy, etc. The Department reserves the right to require complete copies of insurance policies or self-insured memorandums of coverage at all times.

ATTACHMENT I to Contract No. Insert Contract Number

Rev. 4/2019

BUSINESS ASSOCIATE AGREEMENT

PARTIES

This Business Associate Agreement (Agreement) is entered into between the Department of Public Health and Human Services, (the "Department"), State of Montana (State), whose contact information is as follows: 100 N. Park, Suite 300, Helena, MT, 59620-2905, Phone Number (406) 444-3964, Fax Number (406) 444-9389, and Insert Contractor Name (Business Associate), whose contact information is as follows: Federal Tax ID Number Insert Federal Tax ID Number, Insert Street Address, Insert City, Insert State, Insert Zip Code, Phone Number Insert Phone Number, and Fax Number Insert Fax Number.

THE PARTIES AGREE AS FOLLOWS:

1. Business Associate Status

a. The Department is subject to and must comply with provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 U.S.C. § 1320d-d8, and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the American Recovery and Reinvestment Act of 2009, as codified at 42 U.S.C. §§ 300jj et seq. and §§ 17901, et seq. and the implementing regulations for the two acts at 45 CFR Parts 160, 162 and 164.

b. The Department has determined it is a hybrid entity as defined in the implementing regulations, that is a covered entity performing both covered and non-covered functions. Under the HIPAA and HITECH and the implementing regulations, the Business Associate, as an entity that performs or assists in the performance of an administrative or data function for the Department involving the use or disclosure of protected health information (PHI) for the Department, is acting as a business associate of a covered entity.

2. Definitions that Apply to This Agreement

Terms used in this Agreement have the same meaning as those terms in the HIPAA and HITECH Acts and the implementing regulations.

3. Status as a Business Associate

The Business Associate agrees that it is a Business Associate of the Department, as defined at 45 CFR § 160.103, and further agrees that it is obligated to comply with the terms of this Agreement and with the requirements of the HIPAA and HITECH Acts and the implementing regulations.

4. Obligations of Business Associate

The Business Associate, as a business associate of the Department, must:

a. use or disclose PHI, including E-PHI, only as is permitted or required by this Agreement, in compliance with the Department's minimum necessary standard policies and procedures, or by applicable law inclusive of 45 CFR Parts 160, 162 and 164;

b. use appropriate safeguards to prevent use or disclosure of PHI and E-PHI other than as provided for by this Agreement or by law;

c. implement appropriate administrative, physical and technical security safeguards as set forth in § 164.306, § 164.308, and § 164.312, that reasonably and appropriate protect the confidentiality, integrity, and availability of PHI and prevent use or disclosure of the PHI other than as provided for by this Agreement;

d. mitigate to the extent practicable and as may be directed by the Department any harmful effect that is known to the Business Associate of a use or disclosure of PHI by the Business Associate that is in violation of the requirements of this Agreement;

e. report in a timely manner as required by law and this Agreement to the Department any use or disclosure of the PHI not provided for by this Agreement inclusive of uses and disclosures of information that are not in compliance with the minimum necessary standard;

f. report to the Department any security incident of which it becomes aware, and at the request of the Department must identify: i) the date of the security incident, ii) the scope of the security incident, iii) the Business Associate's response to the security incident, and iv) the identification of the party responsible for causing the security incident, if known;

g. enter, as required by 45 CFR § 164.504, into Business Associate Agreements containing the terms and conditions as required by the HIPAA and HITECH Acts and the implementing regulations and as are stated in this Agreement, with any subcontractors performing services in relation to the services being provided by the Business Associate for the Department that involve PHI; and

h. make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of the Department, available to the Department, or to the Secretary of the Federal Department of Health and Human Services in accordance with 45 CFR § 164.408, in a time and manner prescribed by the Department or designated by the Secretary, for purposes of the Secretary determining the Department's and the Business Associate's compliance with the Privacy Regulation, the Security Regulation, and the HITECH Act;

i. document disclosures of PHI and collect information related to those disclosures necessary for the Department to respond to a request by a person for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528 and Section 13405(c) of the HITECH Act;

j. provide to the Department or a person, in time and manner prescribed by the Department, documentation necessary for the Department to respond to a request by a person for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Notwithstanding

45 CFR § 164.528(a)(1)(i), the Business Associate must document disclosures of PHI made through an electronic health record to carry out treatment, payment or health care operations as provided by 45 CFR § 164.506 in the six years prior to the date on which the accounting is requested, and to collect information related to such disclosures as required by the Secretary in regulation pursuant to Section 13405(c)(2) of the HITECH Act;

k. implement a response program, in compliance with Section 13402 of the HITECH Act and implementing regulations, and Subpart D of 45 CFR Part 164 that specifies the actions to be taken when the Business Associate detects or becomes aware of unauthorized access to information systems. The response program must include the following features:

(i) The Business Associate must notify the Department, by facsimile or telephone, of any breach or suspected breach of its security related to areas, locations, or computer system which contain unsecured PHI, including, without limitation, any instance of theft, unauthorized access by fraud, deception, or other malfeasance or inadvertent access (an "incident") in accordance to 45 CFR § 164.410, as promptly as possible, upon having reason to suspect that an incident may have occurred or determining the scope of any such incident, but in no event later than two (2) calendar days upon having reason to suspect that an incident may have occurred;

(ii) In the event of any incident, the Business Associate must provide to the Department, in writing, those details concerning the incident as the Department may request, and must cooperate with the Department, its regulators and law enforcement to assist in regaining possession of the unsecured PHI and in preventing its further unauthorized use, and take any necessary remedial actions as may be required by the Department to prevent other or further incidents;

(iii) If the Department determines that it may need to notify any person(s) as a result of such incident that is attributable to the Business Associate's breach of its obligations under this Agreement, the Business Associate must bear all reasonable direct and indirect costs associated with the determination, including, without limitation, the costs associated with providing notification to the affected person, providing fraud monitoring or other services to affected persons and any forensic analysis required to determine the scope of the incident;

(iv) The Business Associate, working in cooperation with the Department, must update the notice provided to the Department under this Agreement of the incident to include, to the extent possible and as soon as possible, the identification of each person whose unsecured PHI has been, or is reasonably believed by the Business Associate or the Department to have been accessed, acquired, used or disclosed during the incident and must provide any of the following information the Department is required to include in its notice to the person pursuant to 45 CFR § 164.404(c):

(A) A brief description of what happened, including the date of the incident and the date of the discovery of the incident, if known;

(B) A description of the types of unsecured PHI that were involved in the incident (e.g., Social Security Number, full name, date of birth, address, diagnosis);

(C) Any steps the person should take to protect themselves from potential harm resulting from the incident;

(D) A brief description of what is being done to investigate the incident, mitigate the harm, and protect against future incidents;

(E) Contact procedures for persons to ask questions or learn additional information which shall include a toll-free number, an e-mail address, website, or postal address;

(F) This additional information must be submitted to the Department immediately at the time the information becomes available to the Business Associate;

(v) limit its use and disclosure of PHI created or received by the Business Associate from or on behalf of the Department to uses or disclosures as are permitted to the Business Associate under the applicable requirements of 45 CFR § 164.504(e) and the HITECH Act and the terms of this Agreement. The Business Associate must also comply with the additional requirements of Subtitle D of the HITECH Act that relate to privacy and that apply to covered entities and to the Business Associate as a business associate; and

(vi) respond to a person's request under 45 CFR § 164.522(a)(1)(i)(A) that the Business Associate restrict the disclosure of the person's PHI.

5. Permitted Uses, Disclosures and Limitations

a. Except as otherwise limited in this Agreement, the Business Associate may use or disclose PHI on behalf of, or to provide services to, the Department for the following purposes, if such use or disclosure of PHI would not violate the requirements of the HIPAA and HITECH Acts and the implementing regulations if done by the Department or otherwise violate the minimum necessary policies and procedures of the Department: Substance Use Disorders and Co-occurring Treatment Services.

b. The Business Associate may use PHI to report violations of federal and state laws to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1) and (2).

c. The Business Associate, as required by 45 CFR § 164.504(e)(1)(iii), must terminate any business associate agreement with a subcontractor that violates the requirements of this Agreement or the applicable law.

d. The Business Associate shall not directly or indirectly receive remuneration in exchange for PHI that is created or received by the Business Associate from or on behalf of the Department.

6. Use and Disclosure for Business Associate's Purposes

a. The Business Associate must use and disclose PHI that is created or received by the Business Associate from or on behalf of the Department in compliance with each applicable requirement of 45 CFR § 164.504(e) and the HITECH Act.

b. The Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate provided that:

(i) the disclosures are required by law;

(ii) the disclosures are expressly authorized in this Agreement by the Department;

(iii) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only for the purpose for which it was disclosed to the person; and

(iv) the Business Associate requires the person to whom the information is disclosed to report immediately any incident of which it is aware in which the confidentiality of the information has been breached.

c. The Business Associate may only use PHI for Data Aggregation purposes if the Department in this Agreement expressly authorizes those purposes and the Data Aggregation is permitted in accordance with 42 CFR § 164.504(e)(2)(i)(B).

d. To the extent otherwise permitted by this Agreement, a communication that is described in the definition of Marketing in 45 CFR § 164.501 for which the Department receives or has received Direct or Indirect Payment (excluding payment for Treatment) in exchange for making such communication, shall not be considered a Health Care Operation unless:

(i) such communication describes only a drug or biologic that is currently prescribed for the recipient of the communication and any payment received in exchange for making such a communication is reasonable in amount; or

(ii) the communication is made by the Business Associate on behalf of the Department and the communication is otherwise consistent with this Agreement. No communication may be made by the Business Associate without prior written authorization by the Department.

7. Obligations of the Department

a. The Department must notify the Business Associate of any limitation(s) in the Department's notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of PHI. A copy of the Department's Notice of Privacy Practice is attached to this Agreement and incorporated herein.

b. The Department must notify the Business Associate of any changes in, or revocation of, permission by a person to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

c. The Department must notify the Business Associate of any restriction to the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. The Department, except as may be expressly agreed to by the parties and stated in this Agreement, may not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the requirements of the HIPAA and HITECH Acts and the implementing regulations if done by the Department.

8. Term and Termination

a. The term of this Agreement shall be effective as of the effective date that the Business Associate begins delivery of its services and shall terminate when all of the PHI provided by the Department to the Business Associate, or created or received by the Business Associate on behalf of the Department, is destroyed or returned to the Department, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this subsection.

b. Upon the Department's knowledge of a breach, as defined in § 164.402, by the Business Associate, the Department, as its sole discretion, must provide an opportunity for the Business Associate to:

(i) cure the breach; or
(ii) end the violation and terminate this Agreement if the Business Associate does not cure the breach; or
(iii) end the violation within the time specified by the Department; or
(iv) immediately terminate this Agreement if the Business Associate has breached a material term of this Agreement and cure is not possible; or
(v) if neither termination nor cure are feasible, the Department must report the violation to the Secretary.

c. Upon the Business Associate's knowledge of a material breach by the Department, the Business Associate must either:

(i) notify the Department of such breach in reasonable detail, and provide an opportunity for the Department to cure the breach or violation; or
(ii) if cure is not possible, the Business Associate may immediately terminate this Agreement; or
(iii) if neither termination nor cure is feasible, the Business Associate shall repot the violation to the Secretary.

d. The Department may unilaterally terminate this Agreement with the Business Associate upon thirty (30) days written notice in the event:

(i) the Business Associate does not promptly enter into negotiations to amend this Agreement when requested by the Department pursuant to the terms of this Agreement; or
(ii) the Business Associate does not enter into an amendment to this Agreement providing assurance regarding the safeguarding of PHI that the Department, in its sole discretion, deems sufficient to satisfy the standards and requirements of the HIPAA and HITECH Acts and the implementing regulations.

9. Effect of Termination

a. Except as provided in this subsection, upon termination of this Agreement, for any reason, the Business Associate shall at the Department's sole discretion return or destroy all PHI received from the Department, or created or received by Business Associate on behalf of the Department. This Agreement shall apply to PHI that is in the possession of subcontractors or agents of the Business Associate. The Business Associate shall retain no copies of the PHI.

b. In the event that the Business Associate determines that returning or destroying the PHI is infeasible, the Business Associate must provide to the Department notification of the conditions that make return or destruction infeasible. Upon written agreement by the Department that return or destruction of PHI is infeasible, the Business Associate must extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains such PHI.

10. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Regulation or Security Regulation means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Department to comply with the requirements of the HIPAA and HITECH Acts and the implementing regulations.

c. Survival. The respective rights and obligations of the Business Associate under this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Department to comply with the requirements of the HIPAA and HITECH Acts and the implementing regulations.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

By: _____ Date: _____
Insert Name, Insert Title

BUSINESS ASSOCIATE

By: _____ Date: _____
Insert Name, Insert Title

ATTACHMENT J to Contract No. Insert Contract Number

ASSURANCES

DEPARTMENT'S ANNUAL CERTIFICATION

DPHHS GS-301
Rev. 5/2019

ANNUAL CERTIFICATION FOR DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES OF THE CONTRACTOR'S COMPLIANCE WITH CERTAIN STATE AND FEDERAL REQUIREMENTS

This annual certification form is standardized for general use by the Department Of Public Health And Human Services (Department) in contracting relationships. Not all of these assurances may be pertinent to the Contractor's circumstances. The Contractor in signing this form is certifying compliance only with those requirements that are legally or contractually applicable to the circumstances of the contractual relationship of the Contractor with the Department.

These assurances are in addition to those stated in the federal OMB 424B (Rev. 7-97) form, known as "ASSURANCES - NON-CONSTRUCTION PROGRAMS", issued by the federal Office of Management of the Budget (OMB). Standard Form 424B is an assurances form that must be signed by the Contractor if the Contractor is to be in receipt of federal monies.

There may be program specific assurances, not appearing either in this form or in the OMB Standard Form 424B, for which the Contractor may have to provide additional certification.

This form and OMB Standard Form 424B are to be provided with original signatures to the Department's contract liaison. The completed forms are maintained by the Department in the pertinent procurement and contract files.

Further explanation of several of the requirements certified through this form may be found in the text of related contract provisions and in the Department's policies pertaining to procurement and contractual terms. In addition, detailed explanations of federal requirements may be obtained through the Internet at sites for the federal departments and programs and for the Office for Management of the Budget (OMB) and the General Services Administration (GSA).

ASSURANCES

The **Contractor**, Insert Contractor Name, for the purpose of contracting with the Montana Department of Public Health & Human Services, by its signature on this document certifies to the Department its compliance, as may be applicable to it, with the following requirements.

The Contractor assures the Department:

GENERAL COMPLIANCE REQUIREMENTS

A. That the Contractor does not engage in conflicts of interest in violation of any state or federal legal authorities, any price fixing or any other anticompetitive activities that violate the

federal antitrust Sherman Act, 15 U.S.C. §§1 – 7, Anti-Kickback Act, 41 U.S.C. §§ 51-58, and other federal legal authorities. And that the Contractor does not act in violation of 18-4-141, MCA or other legal authorities by colluding with other contractors for the purpose of gaining unfair advantages for it or other contractors or for the purpose of providing the services at a noncompetitive price or otherwise in a noncompetitive manner.

B. That the Contractor does not act in violation of the federal False Claims Act at31 U.S.C. §§ 3729 3733(the "Lincoln Law") or of the Montana False Claims Act, at Title 17, chapter,8, part 4, MCA. And that the Contractor and its employees, agents and subcontractors act to comply with requirements of the federal False Claims Act by reporting any credible evidence that a principal, employee, agent, contractor, subgrantee, subcontractor, or other person has submitted a false claim to the federal government.

C. That the Contractor is solely responsible for and must meet all labor, tax, and other legal Authorities requirements pertaining to its employment and contracting activities, inclusive of insurance premiums, tax deductions, unemployment and other tax withholding, overtime wages and other employment obligations that may be legally required with respect to it.

D. That the Contractor maintains necessary and appropriate workers compensation insurance coverage.

E. That the Contractor is an independent contractor and possesses, unless by law not subject to or exempted from the requirement, a current independent contractor certification issued by the Montana Department Of Labor And Industry in accordance with 39-71-417 through 39-71-419, MCA.

F. That the Contractor's subcontractors and agents are in conformance with the requirements of Sections B, C, and D of this Certification.

G. That the Contractor, any employee of the Contractor, or any subcontractor in the performance of the duties and responsibilities of the proposed contract: 1) are not currently suspended, debarred, or otherwise prohibited in accordance with 2 CFR Part 180, OMB Guidelines To Agencies On Government wide Debarment and Suspension (nonprocurement) from entering into a federally funded contract or participating in the performance of a federally funded contract; and 2) are not currently removed or suspended in accordance with 18-4-241, MCA from entering into contracts with the State Of Montana.

H. That the Contractor is in compliance with those provisions of the privacy, security, electronic transmission, coding and other requirements of the federal Health Insurance Portability And Accountability Act of 1996 (HIPAA) and the federal Health Information Technology For Economic And Clinical Health (HITECH), a part of the American Recovery And Reinvestment Act Of 2009, and the implementing federal regulations for both acts that are applicable to contractual performance if the Contractor is either a Covered Entity or a Business Associate as defined for purposes of those acts.

I. That, as required by legal authorities or contract, the Contractor maintains smoke and tobacco free public and work sites. And if the contract performance is related to the delivery of a human service, the Contractor does not perform any work involved in the production, processing, distribution, promotion, sale, or use of tobacco products or the promotion of tobacco companies;

or 3) accept revenues from the tobacco industry or subsidiaries of the tobacco industry if the acceptance results in the appearance that tobacco use is desirable or acceptable or in the appearance that the Contractor endorses a tobacco product or the gifting tobacco related entity.

COMPLIANCE REQUIREMENTS FOR FEDERALLY FUNDED CONTRACTS

J. That the Contractor, in conformance with the Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*), prohibits smoking at any site of federally funded activities that serve youth under the age of 18. This federal prohibition is not applicable to a site where the only federal funding for services is through Medicaid monies or the federally funded activity at the site is inpatient drug or alcohol treatment.

K. That the Contractor does not expend federal monies in violation of federal legal authorities prohibiting expenditure of federal funds on lobbying the United States Congress or state legislative bodies or for any effort to persuade the public to support or oppose legislation.

L. That the Contractor maintains in compliance with the Drug-Free Workplace Act of 1988, 41 U.S.C. 701, et seq., drug free environments at its work sites, providing required notices, undertaking affirmative reporting, and other requirements, as required by federal legal authorities.

M. That the Contractor is not delinquent in the repayment of any debt owed to a federal entity.

N. That the Contractor, if expending federal monies for research purposes, complies with federal legal authorities relating to use of human subjects, animal welfare, biosafety, misconduct in science and metric conversion.

O. That the Contractor, if receiving aggregate payments of medicaid monies totaling $5,000,000 or more annually, has established in compliance with 1902(a)(68) of the Social Security Act, 42 U.S.C. 1396a(a)(68), written policies with educational information about the federal False Claims Act at 31 U.S.C. §§ 3729–3733 (the “Lincoln Law”) and presents that information to all employees.

P. That the Contractor is in compliance with the executive compensation reporting requirement of the Federal Funding Accountability And Transparency Act (FFATA or Transparency Act), P.L. 109-282, as amended by Section 6202(a), P.L. 110-252-1, either in that the Contractor does not meet the criteria necessitating the submittal of a report by an entity or in that, if the Contractor meets the criteria mandating reporting, the Contractor produces the information in a publicly available report to the Securities And Exchange Commission (SEC) or to the Internal Revenue Service and provides the report in a timely manner to the Department or produces a separate report with the information and submits that report to the in a timely manner to the Department.

Q. That the Contractor, if a contractor for the delivery of medicaid funded services, is in compliance with the requirements of 42 C.F.R. §§ 455.104, 455.105, and 455.106 concerning disclosures of ownership and control, business transactions, and persons with criminal convictions.

R. That the Contractor, if providing federally funded health care services, is not as an entity currently federally debarred from receiving reimbursement for the provision of federally funded health care services and furthermore does not currently have any employees or agents who are

federally debarred from the receiving reimbursement for the provision of federally funded health care services.

COMPLIANCE REQUIREMENTS FOR FEDERALLY FUNDED CONTRACTS INVOLVING THE PURCHASE OR DEVELOPMENT OF PROPERTY

S. That the Contractor manages any real, personal, or intangible property purchased or developed with federal monies in accordance with federal legal authorities.

T. That the Contractor, if expending federal monies for construction purposes or otherwise for property development, complies with federal legal authorities relating to flood insurance, historic properties, relocation assistance for displaced persons, elimination of architectural barriers, metric conversion and environmental impacts.

U. That the Contractor, if the contract exceeds $100,000, complies with mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the federal Energy Policy and Conservation Act, Pub. L. 94-163, 42 U.S.C. §6321 et. seq.

V. That the Contractor, if the contract exceeds $100,000, complies with all applicable standards, orders and requirements issued under section 306 of the Clean Air Act, 42 U.S.C. 7607, section 508 of the Clean Water Act, 33 U.S.C. 1368, Executive Order 11738, and U.S. Environmental Protection Agency regulations, 40 C.F.R. Part15 and that if the Contractor enters into a subcontract that exceeds $100,000 these requirements are in that contract.

CONTRACTOR

BY: _____ Date: _____

Insert Name, Insert Title

DPHHS GS-302
Rev. 06/2018

SOURCES OF INFORMATION ON THE PRIVACY, TRANSACTIONS AND SECURITY REQUIREMENTS PERTAINING TO HEALTH CARE INFORMATION OF THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND THE FEDERAL HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH), ENACTED AS PART OF THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

The following are sources of information concerning the applicability of and implementation of the privacy, transactions and security requirements of HIPAA and HITECH. The Department Of Public Health & Human Services requires that contractors generating, maintaining, and using health care information in relation to recipients of State administered and funded services be compliant with the requirements of HIPAA and HITECH as applicable under the federal legal authorities and the status of the Department as a health care plan.

There can be difficulty in interpreting the applicability of the HIPAA and HITECH requirements to an entity and various circumstances. It is advisable to retain knowledgeable experts to advise concerning determinations of applicability and appropriate compliance.

Websites specified here may be changed without notice by those parties maintaining them.

FEDERAL RESOURCES

The following are official federal resources in relation to HIPAA and HITECH requirements. These are public sites. Implementation of the additional requirements under HITECH, due to the more recent date of enactment, is occurring on an ongoing basis.

1) U.S. Department Of Health & Human Services / Office Of Civil Rights www.hhs.gov/ocr/hipaa

The federal Department Of Health & Human Services / Office Of Civil Rights (OCR) provides information pertaining to privacy and security requirements under HIPAA and HITECH including the adopted regulations and various official interpretative materials. This site includes an inquiry service. OCR is responsible for the implementation of the privacy and security aspects of HIPAA/HITECH and serves as both the official interpreter for and enforcer of the privacy requirements.

2) U.S. Department Of Health & Human Services / Centers For Disease Control & Prevention
http://www.cdc.gov/Other/privacy.html

The federal Department Of Health & Human Services / Centers For Disease Control & Prevention (CDC) provides information pertaining to the application of privacy requirements under HIPAA to public health activities and programs.

STATE RESOURCES

The Department Website For Medicaid Provider Information provides general information for providers of services on compliance with various state and federal requirements. https://medicaidprovider.mt.gov/

Further information concerning HIPAA/HITECH compliance in the delivery of services funded through the Department's various programs can be reviewed at the Department Website for DPHHS HIPAA Policies.
https://dphhs.mt.gov/HIPAA

Certain departmental programs may have more detailed guidance available in relation to particular programs of services. Inquiries may be directed at a program to determine if further information is available.

PROVIDER ASSOCIATIONS

Many national and state provider associations have developed extensive resources for their memberships concerning HIPAA/HITECH requirements. Those are important resources in making determinations as to the applicability and implementation of HIPAA/HITECH.

CONSULTANT RESOURCES

There are innumerable consulting resources available nationally. The Department does not make recommendations or referrals as to such resources. It is advisable to pursue references before retaining any consulting resource. Some consulting resources may be inappropriate for certain types of entities and circumstances.

ASSURANCES NON-CONSTRUCTION OMB 424

OMB Approval No. 0348-0040 ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions reducing this burden, to the Office of Management and Budget, Paperwork Reduction project (0348-0040), Washington, DC 20503. **PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurance. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include, but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§ 1681-1683 and 1685-1686), which prohibit discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§ 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. 290 dd-3 and 290 ee-3) as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. § 2601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (I) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-66), which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§ 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§ 276a to 276a-7), the Copeland Act (40 U.S.C. § 276c and 18 U.S.C. §§ 874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§ 327-333, regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard are to participate in the program and to purchase flood insurance if the total

cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approval State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955k, as amended (42 U.S.C. § 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. 470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling and treatment of warm blooded animals held for research, teaching or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§ 4801 et seq.) Which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL _____ Insert Contractor Name	TITLE Insert Title
APPLICANT ORGANIZATION Insert Provider Organzation Name	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

DISCLOSURE OF LOBBYING ACTIVITIES
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

Approved by OMB
0348-0046

1. Type of Federal Action: ☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	**2. Status of Federal Action**: ☐ a. bid/offer/application ☐ b. initial award ☐ c. post-award	**3. Report Type:** ☐ a. initial filing ☐ b. material change **For Material Change Only:** Year _____ quarter _____ Date of last report _____

(See reverse for public burden disclosure)

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier _____, if known **Congressional District, if known:**	**5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:** **Congressional District, if known:**
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, if applicable: _____
8. Federal Action Number, if known:	**9. Award Amount, if known:** $ _____
10. a. Name and Address of Lobbying Registrant (If individual, last name, first name, MI):	**b. Individuals Performing Services** (including address if different from No. 10a) (last name, first name, MI):
11. Information requested through this form is authorized by Title 31 U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____

Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawarded or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to Title 31 U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include, but are not limited to, subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in Item 4 checks “Subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award of loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number, the contract, grant or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., “RFP-DE-90-001".
9. For a covered Federal action, where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in Item 4 to influence the covered Federal action.
    (b) Enter the full names of the individual(s) performing services and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).11. The certifying official shall sign and date the form, print his/her name, title and telephone number.

FFATA COMMON DATA ELEMENTS AND COMPENSATION REPORT

PHHS-FB-180
Rev. 4/2019

State of Montana
Department of Public Health and Human Services
Business and Financial Services Division

Federal Funding Accountability and Transparency Act
FFATA Summary: FFATA Common Data Elements Report
Section 1: Sub-Award Information Required for Reporting

This report must be completed upon contract obligation of >$25,000.

MT Item	MT Data Element	Insert Data	Description
FFATA-1-01	Subrecipient DUNS Number	Insert Subrecipient DUNS Number	Provide subrecipient organization's 9-digit Data Universal Numbering System (DUNS) number or Central Contractor Registration plus 4 extended DUNS number.
FFATA-1-02	DPHHS Contract Number	Insert DPHHS Contract Number	Provide contract/grant/award number (if any) assigned to the subrecipient award by recipient.
FFATA-1-02-A	Grant Award Name	Insert Grant Award Name	Provide grant/award name assigned by the federal government (i.e. Child Abuse; VR-Independent Living; Immunization; Primary Care; Substance Abuse, etc).
FFATA-1-03	Subrecipient Name	Insert Subrecipient Name	Provide legal name of subrecipient as registered in the Central Contractor Registration (www.ccr.gov).
FFATA-1-04-A	Address Line 1	Insert Address	Physical location as listed in Central Contractor Registration.
FFATA-1-04-B	Address Line 2	Insert Address	
FFATA-1-04-C	City	Insert City	
FFATA-1-04-D	State	Insert State	
FFATA-1-04-E	Zip+4	Insert Zip	
FFATA-1-04-F	Congressional District	Insert Congressional District	AL or 01 for District if MT.
FFATA-1-05	CFDA (Catalog of Federal Domestic Assistance) Number	Insert CFDA Number	If not known, DPHHS will complete.
FFATA-1-06	Total Contract	Insert Contract Value	Provide total amount obligated to subawardee or subcontractor for contract period indicated.

FFATA-1-07	Contract Period	Insert Contract Period	Indicate project/grant period established in subaward document during which sponsorship begins and ends. For multi-year awards for a project/grant period (e.g., 5 years) funded in increments known as budget periods or funding periods, provide total project/grant period, not individual budget period or funding period.
FFATA-1-08-A	Primary Performance City	Insert Performance City	Provide City of primary performance.
FFATA-1-08-B	Primary Performance County	Insert Performance County	Provide County of primary performance.
FFATA-1-08-C	Primary Performance State	Insert Performance State	Provide State of primary performance.
FFATA-1-08-D	Primary Performance Zip+4	Insert Performance Zip	Provide Zip of primary performance.
FFATA-1-08-E	Congressional District	Insert Congressional District	Provide Congressional District of primary performance.
FFATA-1-09	Funding Agency	Insert Funding Agency	If not known, DPHHS will complete.
FFATA-1-10	Brief Description of Purpose of Funding Action	Insert Purpose	

RETURN FORM TO:
DPHHS
ATTN: BFSD-FFATA REPORTING
PO Box 4210
Helena, MT 59604-4210
or
e-Mail: hhsffata@mt.gov

DPHHS-FB-181
Rev. 4/2019

State of Montana
Department of Public Health and Human Services
Business and Financial Services Division

Federal Funding Accountability and Transparency Act
FFATA Summary: FFATA Common Data Elements Report
Section 2: Officers/Executive Compensation Report

This section must be completed upon contract obligation of >$25,000 and yearly thereafter.

CONTRACT TITLE: Insert Contract Title

DPHHS CONTRACT #: Insert DPHHS Contract Number

DUNS #: Insert DUNS #

SUBMITTED BY: Insert Name and Title

INSERT DATE: Insert Submission Date

Is Subrecipient (Contractor) Exempt? Insert Yes or No

	Name	Total Compensation	Title
1.	Insert Name	Insert Amount	Insert Title
2.	Insert Name	Insert Amount	Insert Title
3.	Insert Name	Insert Amount	Insert Title
4.	Insert Name	Insert Amount	Insert Title
5.	Insert Name	Insert Amount	Insert Title

RETURN FORM TO:
DPHHS
ATTN: BFSD-FFATA REPORTING
PO Box 4210
Helena, MT 59604-4210
or
e-Mail: hhsffata@mt.gov

Attachment K to Contract No. Insert Contract Number

DARK MONEY DISCLOSURE DECLARATION

Declaration Form
Dark Money Spending Disclosure Requirements

Contracting Entity shall comply with the State of Montana Executive Order No. 15-2018 requiring the disclosure of dark money spending.

Definitions. As used in this declaration form, the following definitions apply:

Electioneering Communication: A paid communication that is publicly distributed by radio, television, cable, satellite, internet website, mobile device, newspaper, periodical, billboard, mail, or any other distribution of printed or electronic materials, that is made within 60 days of the initiation of voting in an election in Montana, that can be received by more than 100 recipients in the district in Montana voting on the candidate or ballot issue, and that:

a. refers to one or more clearly identified candidates in that election in Montana;
b. depicts the name, image, likeness, or voice of one or more clearly identified candidates in that election in Montana; or
c. refers to a political party, ballot issue, or other question submitted to the voters in that election in Montana.

The term does not mean:

a. a bona fide news story, commentary, blog, or editorial distributed through the facilities of any broadcasting station, newspaper, magazine, internet website, or other periodical publication of general circulation unless the facilities are owned or controlled by a candidate or political committee;
b. a communication by any membership organization or corporation to its members, stockholders, or employees;
c. a commercial communication that depicts a candidate's name, image, likeness, or voice only in the candidate's capacity as owner, operator, or employee of a business that existed prior to the candidacy; or
d. a communication that constitutes a candidate debate or forum or that solely promotes a candidate debate or forum and is made by or on behalf of the person sponsoring the debate or forum.

In this definition, the phrase "made within 60 days of the initiation of voting in an election" means:

a. in the case of mail ballot elections, the initiation of voting occurs when official ballot packets are mailed to qualified electors pursuant to 13-19-206, MCA; or

b. in other elections the initiation of voting occurs when absentee ballot packets are mailed to or otherwise delivered to qualified electors pursuant to 13-13-214, MCA.

Contracting Entity: A bidder, offeror, or contractor.

Covered Expenditure means:

a. A contribution, expenditure, or transfer made by the Contracting Entity, any of its parent entities, or any affiliates or subsidiaries within the entity's control, that:

i. is to or on behalf of a candidate for office, a political party, or a party committee in Montana; or

ii. is to another entity, regardless of the entity's tax status, that pays for an Electioneering Communication, or that makes contributions, transfers, or expenditures to another entity, regardless of its tax status, that pays for Electioneering Communication; and

b. The term excludes an expenditure made by the Contracting Entity, any of its parent entities, or any affiliates or subsidiaries within the entity's control made in the ordinary course of business conducted by the entity making the expenditure; investments; or expenditures or contributions where the entity making the expenditure or contribution and the recipient agree that it will not be used to contribute to candidates, parties, or Electioneering Communication.

Solicitation Requirements. The Contracting Entity shall disclose Covered Expenditures that the Contracting Entity has made within two years prior to submission of its bid or offer.

The disclosure of Covered Expenditures is only required by the bidder/offeror whenever the aggregate amount of Covered Expenditures made within a 24-month period by the bidder/offeror, any parent entities, or any affiliates or subsidiaries within the bidder/offeror's control exceeds $2,500.

If the bidder/offeror meets the disclosure requirements, the bidder/offeror shall submit this signed declaration form indicating "Yes" AND the required disclosure form with its bid/proposal.

If the bidder/offeror does NOT meet the disclosure requirements, the bidder/offeror shall submit this signed declaration form with its bid/proposal indicating "No".

Annual Contract Requirements. The Contracting Entity agrees that if awarded a contract and the contract term exceeds, or has the potential to exceed 24 months, it must annually review and complete a new declaration form and disclosure form, if necessary.

☐ No - I do NOT meet the disclosure requirements. I certify that I have read, understand these requirements and the Contracting Entity has not made Covered Expenditures in excess of $2,500 in the 24 months immediately preceding the submission of this form.

_____
Company Name

_____ _____
Authorized Signature Date

Insert Contract Number

_____
Contract or Solicitation Number

☐ Yes - I meet the disclosure requirements for the 24 months immediately preceding the submission of this form. I have read, understand the requirements and I will complete the necessary disclosure form and submit it with this form.
Disclosure Template: http://sfsd.mt.gov/SPB/Dark-Money

_____
Company Name

_____ _____
Authorized Signature Date

Insert Contract Number

_____
Contract or Solicitation Number

STATE OF MONTANA

Prevention Bureau
Addictive and Mental Disorders Division

CONTRACT APPLICATION

Substance Abuse Block Grant (SABG)
FFY 2022
(10/01/2021 – 9/30/2022)

NAME OF VENDOR: _____

NAME OF PROGRAM FACILITY: _____

NAME OF PROGRAM DIRECTOR: _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____

NAME OF AUTHORIZED REPRESENTATIVE: _____

TITLE OF AUTHORIZED REPRESENTATIVE: _____

DATE: _____

If required documentation is not included, applicant will be notified and must provide requested documentation within 2 business days.

The department cannot guarantee requested funding amounts will be approved in full.

Printed: 2/8/2023 2:31 PM - Montana - OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Section A - Program Contact Information

Main Facility Information								
Mailing Address		Services Offered	Adult		Youth	
City, Zip		Outpatient				
Physical Address		Intensive Outpatient				
City, Zip		Co-occurring				
Days of Operation		Inpatient Residential	M		M	
			F		F	
Hours of Operation		Residential Treatment 3.1 (single gender)	M		M	
			F		F	
ACT Class Times		Residential Treatment 3.1 (women&children)	M		M	
			F		F	
Telephone Number		ACT				
Web Address		MIP				

	Name	Telephone	Email
Director			
Clinical Director			
Office Manager			
Data Coordinator			

The Satellite Facility is a physical and permanent non-mobile setting. The Satellite Facility information must be completed for **each** satellite facility. To add more satellite tables, select the Table by left clicking in the table; next left click on the box with an "X" at the upper left corner of the table to select the entire table. The Table should turn blue. Next, right click for the dropdown menu; left click on "copy". Left click below the current table, press the "enter key" to provide a blank line. Right click for the dropdown menu, left click "paste"

Satellite Facility Information – MUST BE A PHYSICAL AND PERMANENT LOCATION (NON-MOBILE)								
Mailing Address		Services Offered	Adult		Youth	
City, Zip		Outpatient				
Physical Address		Intensive Outpatient				
City, Zip		Co-occurring				
Days of Operation		Inpatient Residential	M		M	
			F		F	
Hours of Operation		Residential Treatment 3.1 (single gender)	M		M	
			F		F	
ACT Class Times		Residential Treatment 3.1 (Women&Children)	M		M	
			F		F	
Telephone Number		ACT				
Web Address		MIP				

	Name	Telephone	Email
Director			
Clinical Director			
Office Manager			
Data Coordinator			

☐ **SECTION B. RESIDENTIAL OR INPATIENT LICENSE**

Provide copy of current year residential or inpatient facility license, if applicable.

☐ **SECTION C. PROGRAM POLICIES**

Current copy of the following program policies must be on file with AMDD. If a copy of the policy was submitted for SFY 21 contracts or as part of the State approval process, and no revisions have been made, you do not need to resubmit the policy.

Indicate with a check mark (✓) below for each policy if the policy in already filed with AMDD or will be resubmitted with revisions to this application.

Policies Required to be on File with AMDD	Already Submitted and No Changes Have Been Made	Changes Have Been Made and Updated Policy is Submitted with this Application
Staff TB testing (*42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127*)		
Client testing for Hepatitis B and C & TB (*42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127*)		
Pregnant women (*42 U.S.C. 300x-27 and 45 C.F.R. 96.131*)		
HIV policies (*42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128*)		
IV Drug Users (*42 U.S.C. 300x-23 and 45 C.F.R. 96.126*)		
Client waiting lists (*42 U.S.C. 300x-23 and 45 C.F.R. 96.126-131*)		
Critical Populations admissions/procedures/priority list (*42 U.S.C. 300x-23 and 45 C.F.R. 96.126-131*)		
Co-occurring screening and treatment policy		
Continuous Quality Improvement process and policy (MCA 53-24-205(3)(a)(i))		

SECTION D. OPERATIONAL REPORT

(MCA 53-24-108(5)(a))

EXPENSES	FY 2021	Projected for FFY 2022
1. Personnel Services (salaries, fringe, benefits, health insurance, work comp, etc.)	$0.00	$0.00
2. Facility Operating Expense (lease, rent, mortgage)	$0.00	$0.00
3. Other expenses (list or I.D. type of expense, utilities, etc.)	$0.00	$0.00
4. Capital Outlay (leasehold improvements, remodel, structure, etc.)	$0.00	$0.00
TOTAL PROGRAM EXPENSE (add items 1 thru 4)	$ 0.00	$ 0.00
REVENUES (Income)		
1. Substance Abuse Block Grant SUD Treatment Contract for Outpatient Services	$0.00	$0.00
2. Substance Abuse Block Grant SUD Treatment Contract for Co-occurring Services	$0.00	$0.00
3. Substance Abuse Block Grant SUD Treatment Contract for Residential/Inpatient Services	$0.00	$0.00
4. County Distribution of Ear Marked Tax (if you have multiple counties provide total for all counties for each payment received below – to the left provide total amount received) November 2020 Amount: $ 00.00 January 2021 Amount: $ 00.00 March 2021 Amount: $ 00.00	$0.00	$0.00
5. Other government contracts and grants	$0.00	$0.00
6. Co-pays, sliding fee schedule, client responsible fees (exclude ACT and MIP Fees)	$0.00	$0.00
7. ACT Fees	$0.00	$0.00
8. MIP Fees	$0.00	$0.00
9. HMK, Standard Medicaid, HELP(TPA) Medicaid	$0.00	$0.00
10. Third Party Payments (insurance, etc.)	$0.00	$0.00
11. Other Revenues (list)	$0.00	$0.00
12. Prevention Funding	$0.00	$0.00
TOTAL REVENUES (add lines 1 thru 13)	$ 0.00	$ 0.00

****REMINDER: TO UPDATE TOTALS FIELDS AFTER AMOUNTS HAVE BEEN ENTERED, CLICK ON TOTAL FIELD AMOUNT AND HIT F9 OR TO UPDATE ENTIRE TABLE HIT CONTROL A, THEN HIT F9 AFTER AMOUNTS HAVE BEEN ENTERED.**

SECTION E. FUNDING REQUEST

FUNDING REQUEST INSTRUCTIONS:

The Substance Abuse Block Grant (SABG) funds are available to cover Substance Use Disorder (SUD) Treatment costs that are not covered by other funding, such as Medicaid, Medicare, and/or private insurance. The SUD Treatment funds must align with the available services outlined in the Medicaid and Non-Medicaid Fee Schedules (attached to this contract application).

Additionally, funding requests must be:

1. Calculated based upon expected need for funding of **Non-Medicaid** covered services of current population served for individuals who fall between 139% and up to 200% of the Federal Poverty Level (FPL). Examples of SABG financial eligibility:
    - One Dependent: 139% is equal to a monthly income of $1,495.00; 200% is equal to a monthly income of $2,146.66.
    - Four Dependents: 139% is equal to a monthly income of $3,075.00; 200% is equal to a monthly income of $4,416.66.
2. At or below actual spending of current contract year unless a detailed implementation plan is provided for funding that exceeds amount spent in FY21. Depending on proposed request and availability of SABG funding, AMDD may not be able to fund your full request and propose a scaled-down plan for proposed services.
3. Prioritized for critical populations (pregnant using IV drugs, pregnant or a woman with children, individuals using IV drugs, families involved with Children & Family Services).

Funding Request – Adult Outpatient

Contract Year	Contract Amount Awarded	Contract Amount Used	Number of Clients Served	Contract Year	Contract Amount Requested	Estimated Number of Clients Served
FFY2021	**$**	**$**		**FFY2022**	**$**	

Please be sure your funding request factors in the financial eligibility for SABG funds. Do not request funding for individuals who are Medicaid eligible or may have private insurance.

Provide detailed description of evidence-based programming used for this funding request.

Response:

Provide detailed description of services and when services are offered for this funding request.

Response:

If requesting funding above projected current FFY contract spending, provide detailed description and plan of how funding will be spent with monthly target amounts.

Plan:

Funding Request – Adolescent Outpatient (Office & School Setting)

Contract Year	Contract Amount Awarded	Contract Amount Used	Number of Clients Served	Contract Year	Contract Amount Requested	Estimated Number of Clients Served
FFY2021	**$**	**$**		**FFY2022**	**$**	

Requests for Adolescent Outpatient services include School Based Therapy and Office Based Therapy.

Please be sure your funding request factors in the financial eligibility for SABG funds. Do not request funding for individuals who are Medicaid eligible or may have private insurance.

Provide detailed description of evidence-based programming used for this funding request.

Response:

Provide detailed description of services and when services are offered for this funding request.

Response:

If requesting funding above projected current FFY contract spending, provide detailed description and plan of how funding will be spent with monthly target amounts.

Plan:

Funding Request – Co-occurring Services

Contract Year	Contract Amount Awarded	Contract Amount Used	Number of Clients Served	Contract Year	Contract Amount Requested	Estimated Number of Clients Served
FFY2021	**$**	**$**		**FFY2022**	**$**	

Please be sure your funding request factors in the financial eligibility for SABG funds. Do not request funding for individuals who are Medicaid eligible or may have private insurance.

Provide detailed description of evidence-based programming used for this funding request.

Response:

Provide # of clinicians providing co-occurring services: - staff ___ contracted ___

Provide detailed description and when services are offered for this funding request.

Response:

If requesting funding above projected current FFY contract spending, provide detailed description and plan of how funding will be spent with monthly target amounts.

Plan:

Funding Request – Clinically Managed Low-Intensity Residential Services (ASAM 3.1 Services)

FFY 2021 Contract Year	Contract Amount Awarded	Contract Amount Used	Number of Clients Served	FFY2022 Contract Year	Contract Amount Requested	Estimated Number of Clients Served
Room & Board	$	$		Room & Board	$	
Psychosocial Rehab	$	$		Psychosocial Rehab	$	

These funds cover Room and Board rate and Psychosocial Rehab (as outlined on the Non-Medicaid Fee Schedule) for licensed 3.1 Residential Treatment Facilities. Please note: Psychosocial Rehab is only billable to the SABG SUD Treatment contract for individuals admitted to a 3.1 level of care and receiving OP (not IOP) servies, since Psychosocial Rehab is included in the IOP bundled rate.

Please refer to the Non-Medicaid Fee Schedule (attached) and the Non-Medicaid and Medicaid Provider Manual for guidance on these billable services.

AMDD Non-Medicaid Services Provider Manual (mt.gov)

AMDD Medicaid Services Provider Manual (mt.gov)

Provide detailed description of evidence-based programming used for this funding request.

Response:

Please specify the number of clients who may need Room/Board and Psychosocial Rehab Services who are Medicaid eligible and who are above Medicaid eligibility up to 200% FPL. Please estimate the number of clients to be served in the above funding request who meet this criterion.

Estimated Number of clients needing 3.1 Level of Care who meet Medicaid eligibility:

Estimated Number of clients needing 3.1 Level of Care who are above Medicaid eligibility up to 200% FPL:

Location and Number of Beds: Provide name, location, and number of beds for each location to be supported through this funding request. If multiple homes or buildings are identified, provide contract amount requested for each home.

Response:

If requesting funding above projected current FFY contract spending, provide detailed description and plan of how funding will be spent with monthly target amounts.

Plan:

Funding Request - Peer Support Services

FFY 2021 Contract Year	Contract Amount Awarded	Contract Amount Used	Number of Clients Served	FFY2022 Contract Year	Contract Amount Requested	Estimated Number of Clients Served
				Peer Support	$	

Provide detailed description of how Certified Behavioral Health Peer Support Specialist(s) (CBHPSS) will be used to support clients during the continuum of care. Include information on types of activities that will be provided and how it wraps into the overall treatment plan.

Response:

Individual Peer Services are available for clients above Medicaid eligibility up to 200% FPL. Please indicate the CBHPSS to client ratio and what services will be provided.

Response:

Group Peer Services are allowable as a "pilot" under this SABG contract for both Medicaid and Non-Medicaid clients. A "pilot" for group peer support is defined as an intervention to identify and determine whether the group peer support services in improving client outcomes. Please see (LINK) for Group Peer Support requirements.
https://dphhs.mt.gov/Portals/85/amdd/documents/SubstanceAbuse/CertifiedBehavioralHealthPeerSupportSABGContractFFY2021.pdf

If you are seeking SABG funds for group peer support, please include a plan to describe the group peer services and how those services are evaluated for client progress. If funding was utilized in FFY 21 for group peer support, please explain the successes and challenges and any changes that will be made to the delivery model and evaluation plan.

Response

Funding Request – Medication Assisted Treatment Medications

Contract Year	Contract Amount Awarded	Contract Amount Used	Number of Clients Served	Contract Year	Contract Amount Requested	Estimated Number of Clients Served
FFY2021				**FFY2022**	**$**	

Provide detailed description of how MAT will be integrated into your service delivery system. Please identify the waivered provider who will be overseeing the MAT service and projected number of clients to receive MAT services who are above Medicaid eligibility up to 200% FPL and do not have private insurance to cover these services.

Please refer to the Non-Medicaid Fee Schedule for allowable rates.

Response:

Provide detailed description of what FDA approved medications will be available and when services are offered for this funding request.

Response:

Funding Request – Travel and Training Request up to $5,000 Total Request

	Contract Year	Contract Amount Requested	Estimated Number Served
Travel Funding Requests: Allowed expenses: **a. from main facility to satellite location(s) greater than 30 miles from main facility.** **b. to alternative treatment settings (home visiting, jails, etc.); services provided must be a covered SABG service.** **c. department sponsored and approved training events.**	**FFY2022**	**$**	

Travel Funding: Provide detailed budget to include destination, mileage, number of trips. Mileage will be reimbursed at current state rates (mileage rates change each January; the rate will adjust up or down to federal per diem requirements). AMDD strongly recommends using telehealth if the number of clients to be seen at a satellite location cannot justify travel expense.

From:	To:	Purpose	Mileage Round Trip	# Trips	Total Request
				Total Travel Request:	**(place this amount above in the Contract Amount Requested)**

Training Services: Provide detailed description of evidence-based training, implementation plan of how training will be implemented into services, outcomes expected and detailed costs.
Note:

- **Training must be authorized prior to implementation**
- **Prime for Life New Instructor Training and Continuing Education Training will now be paid under the SABG contract. The cost for New Instructor Training or Continuing Education is $325 per person. Please plan accordingly to the number of staff who need this training during FY22.**
- **No out-of-state travel is allowed but supporting travel for out of state trainers to provide in-state training is allowable, as long as it is prior-authorized and supports evidence-based treatment.**

	Contract Year	Contract Amount Requested	Estimated Number Served
Training Funding Requests: Can be used to provide evidence-based training for professional development of staff.	**FFY2022**	**$**	

Provide detailed description of training, implementation plan, expected outcomes, and detailed budget of associated costs:

Funding Request – School Based Services (Prevention)

Contract Year	Contract Amount Awarded	Contract Amount Used	Number of Students Served	Contract Year	Contract Amount Requested	Estimated Number of Students Served
FFY2021	**$**	**$**		**FFY2022**	**$**	

School-Based Services (SBS) are evidenced-based primary prevention programs to prevent or reduce youth substance use. SBS are not therapy services, rather services designed to address problems or risk factors related to substance use consequences and are intended to promote protective factors and provide skills development.

These services are limited to the following evidence-based programs and provided by staff who have received training in the model:

- LifeSkills Training®
- Project Towards No Drug Use®
- Team Intervene®
- State-wide Indian Drug Prevention Program®
- Prime for Life

***School based early intervention and therapy services must be included under adolescent services**

Submit a school-based service plan which includes:

- The name of the curriculum to be implemented with plan to implement with fidelity;
- Projected number of students to be served;
- Number of hours of service and days of the week;

Response:

Describe the plan to collect and submit evaluation data **monthly** to the Department on the attached tracking form. The following data will need to be collected:

- Unique Identifier for each student enrolled in the program;
- Student Age;
- Student Gender;
- Perception of risk;
- Intent to make changes; and
- Helpfulness of program

Response:

Provide detailed budget projection based on monthly cost. Include project timelines for implementation

and required student workbooks.
Submit a copy of a Memorandum of Understanding (MOU) with the school(s) where the SBS will be implemented
Attach MOU(s) to the contract application.

Funding Request – Parenting Education Classes for At-Risk Families involved with SUD and Family Services

Contract Year	Contract Amount Awarded	Contract Amount Used	Number of Students Served	Contract Year	Contract Amount Requested	Estimated Number of Students Served
FFY2021	**$**	**$**		**FFY2022**	**$**	

Parenting Education Classes must be evidenced-based programs to improve parenting skills for families admitted in the SUD Treatment program who are also involved with Child Family Services. These services are not therapy services, rather services designed to increase parenting skills and resources to enhance family unification and improve protective factors and life skills development. Positive American Indian Parenting focuses on traditional and culturally specific parenting practices and values. These services must be Evidence-Based Programs, Culturally Responsive Instructional Resources for American Indians, and Pre-Approved by AMDD.

Parenting Education Classes are billed at $50 per session (not per participant) to cover the Instructor's time, regardless of the class size.

Submit an Evidence-Based or American Indian culturally responsive with appropriate parenting educational plan which includes:

- The name of the curriculum to be implemented with plan to implement with fidelity;
- Resource that supports the program is evidence-based and/or culturally effective.
- Projected number of families to be served;
- Number of hours of service and days of the week; and/or
- Name of staff providing the parenting education.

Resources Examples:
SAMHSA

- https://www.nurturingparenting.com/nrepp.html
- http://www.parentinginsideout.org/evidence-based-practices/

Child Welfare Information Gateway: • https://www.childwelfare.gov/topics/preventing/prevention-programs/parented/ • https://www.bing.com/shop?q=evidence+based+parenting+classes&FORM=SHOPPA&originIGUID=A582E8CA3E84481489F099BD8A8FA590 **National Indian Child Welfare Association (NICWA):** • www.tribaljustice.org/.../nicwa-positive-indian-parenting
Response:
Provide detailed budget projection based on monthly cost. Include project timelines for implementation and required workbooks (if needed).

SECTION F: USUAL & CUSTOMARY CHARGES

Provide program's usual and customary charges for services:

Procedure Code	Procedure Codes and Rates Description	Unit Size	Provider's Usual & Customary Charge
90791	Assessment and Placement	Per Assessment	$
90832HF	Individual Psychotherapy with Patient	30 min	$
90832MH	Brief Psychotherapy by LCPC/LCSW	30 min	$
90834HF	Individual Psychotherapy with Patient	45 min	$
90834MH	Individual Therapy by LCPC/LCSW	45 min	$
90837	Individual Therapy	15 min	$
90853	Group Therapy	Per event	$
T1016	Case Management	15 min	$
H0010	Inpatient Residential Detox	Per Day	$
H0012	Day Treatment	Per Day	$
H0018	Inpatient Residential Treatment	Per Day	$
H0015	Adult High Tier SUD Intensive Outpatient Treatment	Per Day	$
H0015HA	Intensive Outpatient (Adolescent)	Per Day	$
H0015HH	Intensive Outpatient Program (Adult High Tier + MH)	Per Day	$
H0015HHH	Intensive Outpatient (Adolescent + MH)	Per Day	$
H2036	Adult Low Tier SUD Intensive Outpatient Treatment	Per Day	$
H2036HH	Intensive Outpatient (Adult Low Tier + MH)	Per Day	$
H0015	Adolescent SUD Intensive Outpatient		
H2034	Recovery Home Room and Board	Per Day	$
H2034HD	Recovery Home – Women & Children Room and Board	Per Day	$
H0048	Saliva Drug Test	Per Test	$
H0003	CLIA Laboratory Performed Blood or Urine Test	Per Test	$
SBS	School Based Services	15 min	$
H2017	Psychosocial Rehabilitation	15 min	$
99408	SBIRT/ATOD Screening – (e.g. Audit, DAST) and brief intervention - 15-30 Minutes	Per visit	$
99409	SBIRT/ATOD Screening – (e.g. Audit, DAST) and brief intervention - 30 Minutes or more	Per Visit	$
90849	Multi-Family Group Therapy	Per Visit	$
90847	Family Therapy with Patient	Per Visit	$
90846	Family Therapy without Patient	Per Visit	$
H0038	Peer Support (Certified) Individual	15 min	$
H0038HQ	Certified Peer Support (Group)	15 min	$
Q3014	Telehealth Originating Site Facility Fee	Per Day	$
	Educational Course for ACT	Per Course	$

Procedure Code	Co-Occurring Procedure Codes and Rates Description	Unit Size	Provider's Usual & Customary Charge
S5102	Mental Health Group Home	Per Day	$
CC	Case Consultation by Psychologist/LCPC	15 min	$
90791-NP	Psychiatric Diagnosis Eval – Non-Medical by Nurse Practitioner/LCPC /LCSW	Per Eval	$
90791-MH	Psychiatric Diagnosis Eval – Non-Medical by LCPC /LCSW	Per Eval	$
90791-MD	Psychiatric Diagnosis Eval – Non-Medical by Physician/Addictionologist	Per Eval	$
90791-PS	Psychiatric Diagnosis Eval – Non-Medical by Psychiatrist	Per Eval	$
90792-NP	Psychiatric Diagnosis Eval – with Medical by Nurse Practitioner	Per Eval	$

Procedure Code	Co-Occurring Procedure Codes and Rates Description	Unit Size	Provider's Usual & Customary Charge
90792-MD	Psychiatric Diagnosis Eval – with Medical by Physician/Addictionologist	Per Eval	$
90792-PS	Psychiatric Diagnosis Eval – with Medical by Psychiatrist	Per Eval	$
90832-NP	Brief Psychotherapy (30 min) by Nurse Practitioner	30 min	$
90832-MH	Brief Psychotherapy (30 min) by LCPC/LCSW	30 min.	$
90832-MD	Brief Psychotherapy (30 min) by Physician /Addictionologist	30 min.	$
90832-PS	Brief Psychotherapy (30 min) by Psychiatrist	30 min.	$
90833-NP	Psychotherapy with E&M (30 min) by Nurse Practitioner	30 min.	$
90833-MD	Psychotherapy with E&M (30 min) by Physician /Addictionologist	30 min.	$
90833-PS	Psychotherapy with E&M (30 min) by Psychiatrist	30 min.	$
90834-NP	Psychotherapy (45 min) by Nurse Practitioner	45 min.	$
90834-MH	Psychotherapy (45 min) by LCPC/LCSW	45 min.	$
90834-MD	Psychotherapy (45 min) by Physician /Addictionologist	45 min.	$
90834-PS	Psychotherapy (45 min) by Psychiatrist	45 min.	$
90836-NP	Psychotherapy with E&M (45 min) by Nurse Practitioner	45 min.	$
90836-MD	Psychotherapy with E&M (45 min) by Physician /Addictionologist	45 min.	$
90836-PS	Psychotherapy with E&M (45 min) by Psychiatrist	45 min.	$
90837 - NP	Psychotherapy (60 min) by Nurse Practitioner	60 min.	$
90837-MH	Psychotherapy (60 min) by LCPC/LCSW	60 min.	$
90837-MD	Psychotherapy (60 min) by Physician /Addictionologist	60 min.	$
90837-PS	Psychotherapy (60 min) by Psychiatrist	60 min.	$
90785-NP	Interactive Complexity by Nurse Practitioner	15 min.	$
90785-MH	Interactive Complexity by LCPC/LCSW	15 min.	$
90785-MD	Interactive Complexity by Physician /Addictionologist	15 min.	$
90785-PS	Interactive Complexity by Psychiatrist	15 min.	$
99201-NP	Office Visit – New Patient (10 Min) by Nurse Practitioner	10 min.	$
99201-MD	Office Visit – New Patient (10 Min) by Physician/Addictionologist	10 min.	$
99201-PS	Office Visit – New Patient (10 Min) by Psychiatrist	10 min.	$
99202-NP	Office Visit – New Patient (20 Min) by Nurse Practitioner	20 min.	$
99202-MD	Office Visit – New Patient (20 Min) by Physician /Addictionologist	20 min.	$
99202-PS	Office Visit – New Patient (20 Min) by Psychiatrist	20 min.	$
99203-NP	Office Visit – New Patient (30 Min) by Nurse Practitioner	30 min.	$
99203-MD	Office Visit – New Patient (30 Min) by Physician /Addictionologist	30 min.	$
99203-PS	Office Visit – New Patient (30 Min) by Psychiatrist	30 min.	$
99204-NP	Office Visit – New Patient (40 Min) by Nurse Practitioner	40 min.	$
99204-MD	Office Visit – New Patient (40 Min) by Physician /Addictionologist	40 min.	$
99204-PS	Office Visit – New Patient (40 Min) by Psychiatrist	40 min.	$
99205-NP	Office Visit – New Patient (50 Min) by Nurse Practitioner	50 min.	$
99205-MD	Office Visit – New Patient (50 Min) by Physician /Addictionologist	50 min.	$
99205-PS	Office Visit – New Patient (50 Min) by Psychiatrist	50 min.	$
99211-NP	Office Visit – Established Patient (5 Min) by Nurse Practitioner	5 min.	$
99211-MD	Office Visit – Established Patient (5 Min) by Physician /Addictionologist	5 min.	$
99211-PS	Office Visit – Established Patient (5 Min) by Psychiatrist	5 min.	$
99212-NP	Office Visit – Established Patient (10 Min) by Nurse Practitioner	10 min.	$
99212-MD	Office Visit – Established Patient (10 Min) by Physician/Addictionologist	10 min.	$
99212-PS	Office Visit – Established Patient (10 Min) by Psychiatrist	10 min.	$
99213-NP	Office Visit – Established Patient (15 Min) by Nurse Practitioner	15 min.	$
99213-MD	Office Visit – Established Patient (15 Min) by Physician /Addictionologist	15 min.	$
99213-PS	Office Visit – Established Patient (15 Min) by Psychiatrist	15 min.	$
99214-NP	Office Visit – Established Patient (25 Min) by Nurse Practitioner	25 min.	$
99214-MD	Office Visit – Established Patient (25 Min) by Physician /Addictionologist	25 min.	$
99214-PS	Office Visit – Established Patient (25 Min) by Psychiatrist	25 min.	$

Procedure Code	Co-Occurring Procedure Codes and Rates Description	Unit Size	Provider's Usual & Customary Charge
99215-NP	Office Visit – Established Patient (40 Min) by Nurse Practitioner	40 min.	$
99215-MD	Office Visit – Established Patient (40 Min) by Physician /Addictionologist	40 min.	$
99215-PS	Office Visit – Established Patient (40 Min) by Psychiatrist	40 min.	$
	List additional procedure codes not included in table above, as applicable. This does not indicate they are payable under funding sources.		

Substance Use Disorder
Non-Medicaid Provider Fee Schedule
Effective July 1, 2020

Evaluation and Management Services

Evaluation and management (E/M) services may be provided by physicians and other qualified health care professionals. Providers will bill using standard CPT E/M procedure codes and are reimbursed according to the Department's RBRVS system. Please refer to https://medicaidprovider.mt.gov

Non-Medicaid Procedure Codes and Rates for Individuals 0-138% of Poverty

Procedure Code	Modifier 1	Description	Unit	Rate	Limits
H2034	HD	SUD Clinically Managed Low Intensity (ASAM 3.1) (Women/children room & board)	per day	$139.03	None
H2034	-	SUD Clinically Managed Low Intensity (ASAM 3.1) (room & board)	per day	$38.09	None
H0003	-	CLIA Laboratory Performed Blood or Urine Test	per test	Up to $23.74	None
SBS	-	School Based Services	15 min	$17.37	None
H2017	-	Psychosocial Rehabilitation	15 min	$12.41	None
H0038	HQ	Peer Support (Certified) Group – (Up to eight members per group.)	15 min	$2.75	8 units per week per member.

Non-Medicaid Procedure Codes and Rates for Individuals 139-200% of Poverty

Intensive Outpatient Bundled Rates

Procedure Code	Modifier 1	Modifier 2	Description	Unit	Rate	Limits
H0015	See below	-	Adult High Tier SUD Intensive Outpatient	per day	$98.55	Four billable days per week
H2036	See below	-	Adult Low Tier SUD Intensive Outpatient	per day	$81.46	Four billable days per week
H0015	See below	HA	Adolescent SUD Intensive Outpatient	per day	$98.55	Four billable days per week

Modifier HH may be used when an individual with a mental health diagnosis from the Diagnostic and Statistical Manual of Mental Disorders receives therapeutic mental health services by the SUD IOP provider. Please note that modifier HH must always be in the first modifier position to trigger payment. Modifier HH will not trigger payment if used in the second modifier position. Using modifier HH will enhance the unit rate by $22.89. For Adolescents, Modifier HA must be the in the first modifier position when Modifier HH is NOT being used.

Medication-Assisted Therapy (MAT)

Procedure Code	Modifier 1	Description	Unit	Rate	Limits
H0016	-	Medication-Assisted Therapy (MAT) Intake	first week of enrollment	$356.41	See Below*
H0016	HG	Medication-Assisted Therapy (MAT)	per week	$127.29	None

*The Medication-Assisted Therapy (MAT) Intake bundled rate is limited to one use per individual per 4-week period. MAT Intake can only be reimbursed for the first week of member's enrollment into the MAT program.

Non-Medicaid Procedure Codes and Rates for Individuals 139-200% of Poverty

Procedure Code	Modifier 1	Description	Unit	Rate	Limits
H0010		SUD Medically Monitored Intensive Inpatient (ASAM 3.7)	per day	$243.61	None
H0018		SUD Clinically Managed High-Intensity (Adult)/Medium-Intensity (Adolescent) Residential (ASAM 3.5)	per day	$243.61	None

H0012		SUD Partial Hospitalization (ASAM 2.5)	per day	$121.80	None
H2034	HD	SUD Clinically Managed Low Intensity (ASAM 3.1) (Women/children room & board)	per day	$139.03	None
H2034		SUD Clinically Managed Low Intensity (ASAM 3.1) (room & board)	per day	$38.09	None
H0048		Dip Strip or Saliva Collection, Handling, and Testing	per test	$8.38	None
H0003		CLIA Laboratory Performed Blood or Urine Test	per test	Up to $23.74	None
SBS		School Based Services	15 min	$17.52	None
H2017		Psychosocial Rehabilitation	15 min	$12.41	None
H0038		Peer Support (Certified) Individual	15 min	$13.73	None
H0038	HH	Peer Support (Certified) Individual (co-occurring)	15 min	$13.73	None
H0038	HQ	Peer Support (Certified) Group – (Up to eight members per group.)	15 min	$2.75	8 units per week per member.

Non-Medicaid Co-occurring Procedure Codes and Rates for Individuals 0-200% of Poverty

Procedure Code	Description	Unit	Rate
CC	Case Consultation by Psychologist/LCPC	15 min	$15.08

Non-Medicaid Procedure Codes and Rates for Individuals – Pharmacy 0-200% of Poverty

Procedure Code	Description	Unit	Rate
J0571-HG	Buprenorphine Oral 1 mg (Subutex)	1 mg	Medicaid Pharmacy Rate
J0572-HG	Buprenorphine/Naloxone up to 3 mg (Suboxone)	Up to 3mg	Medicaid Pharmacy Rate
J0573-HG	Buprenorphine/Naloxone >3.1 <= 6 mg (Suboxone)	3.1- 6 mg	Medicaid Pharmacy Rate
J0574-HG	Buprenorphine/Naloxone >6.1 <= 10 mg (Suboxone)	6.1-10 mg	Medicaid Pharmacy Rate

Procedure Code	Description	Unit	Rate
J0575-HG	Buprenorphine/Naloxone >10 mg (Suboxone)	10.1 mg and up	Medicaid Pharmacy Rate
J0592	Buprenorphine IM or IV 0.1 mg	0.1 mg	Medicaid Pharmacy Rate
J2315	Naltrexone Injection 1 mg (Vivitrol)	1 mg	Medicaid Pharmacy Rate
S0109-HG	Methadone, oral, 5 mg	5 mg	Medicaid Pharmacy Rate
54035613 or other NDC	Disulfiram, 250 mg	250 mg	Medicaid Pharmacy Rate
93535286 or other NDC	Acamprosate, 333 mg	333 mg	Medicaid Pharmacy Rate
3072750 or other NDC	Chlordiazepoxide, 10 mg	10 mg	Medicaid Pharmacy Rate

Non-Medicaid Procedure Codes and Rates for Individuals - RBRVS 139-200% of Poverty

Procedure Code	Description	Unit	Rate
99408	SBIRT/ATOD Screening – (e.g. Audit, DAST) and brief intervention - 15-30 Minutes	per visit	See RBRVS Schedule
99409	SBIRT/ATOD Screening – (e.g. Audit, DAST) and brief intervention - 30 Minutes or more	per visit	See RBRVS Schedule
90832-HF	Individual Psychotherapy with patient	30 min	See RBRVS Schedule
90834-HF	Individual Psychotherapy with patient	45 min	See RBRVS Schedule
90837-HF	Individual Psychotherapy with patient	60 min	See RBRVS Schedule
90853-HF	Group Psychotherapy	per visit	See RBRVS Schedule
90849	Multi-Family Group Therapy	per visit	See RBRVS Schedule
90847	Family Therapy with Patient	per visit	See RBRVS Schedule
90846	Family Therapy without Patient	per visit	See RBRVS Schedule
90791	Psychiatric Diagnostic Evaluation (Assessment & Placement)	per evaluation	See RBRVS Schedule

RBRVS Schedule can be found at https://medicaidprovider.mt.gov

Non-Medicaid Co-occurring Procedure Codes and Rates for Individuals - RBRVS

139-200% of Poverty

Procedure Code	Description	Unit	Rate
90791-NP	Psychiatric Diagnosis Eval–Nonmedical by Nurse Practitioner	per eval	See RBRVS Schedule
90791-MH	Psychiatric Diagnosis Eval–Nonmedical by LCPC /LCSW	per eval	See RBRVS Schedule
90791-MD	Psychiatric Diagnosis Eval–Nonmedical by Physician/Addictionologist	per eval	See RBRVS Schedule
90791-PS	Psychiatric Diagnosis Eval–Nonmedical by Psychiatrist	per eval	See RBRVS Schedule
90792-NP	Psychiatric Diagnosis Eval–with Medical by Nurse Practitioner	per eval	See RBRVS Schedule
90792-MD	Psychiatric Diagnosis Eval–with Medical by Physician/Addictionologist	per eval	See RBRVS Schedule
90792-PS	Psychiatric Diagnosis Eval–with Medical by Psychiatrist	per eval	See RBRVS Schedule
90832-NP	Brief Psychotherapy by Nurse Practitioner	30 min	See RBRVS Schedule
90832-MH	Brief Psychotherapy by LCPC/LCSW	30 min.	See RBRVS Schedule
90832-MD	Brief Psychotherapy by Physician /Addictionologist	30 min	See RBRVS Schedule
90832-PS	Brief Psychotherapy by Psychiatrist	30 min	See RBRVS Schedule
90833-NP	Psychotherapy with E&M by Nurse Practitioner	30 min	See RBRVS Schedule
90833-MD	Psychotherapy with E&M by Physician /Addictionologist	30 min	See RBRVS Schedule
90833-PS	Psychotherapy with E&M by Psychiatrist	30 min	See RBRVS Schedule
90834-NP	Psychotherapy by Nurse Practitioner	45 min	See RBRVS Schedule
90834-MH	Psychotherapy by LCPC/LCSW	45 min.	See RBRVS Schedule
90834-MD	Psychotherapy by Physician/Addictionologist	45 min	See RBRVS Schedule
90834-PS	Psychotherapy by Psychiatrist	45 min	See RBRVS Schedule
90836-NP	Psychotherapy with E&M by Nurse Practitioner	45 min	See RBRVS Schedule
90836-MD	Psychotherapy with E&M by Physician/Addictionologist	45 min	See RBRVS Schedule
90836-PS	Psychotherapy with E&M by Psychiatrist	45 min	See RBRVS Schedule
90837-NP	Psychotherapy by Nurse Practitioner	60 min	See RBRVS Schedule
90837-MH	Psychotherapy by LCPC/LCSW	60 min	See RBRVS Schedule
90837-MD	Psychotherapy by Physician/Addictionologist	60 min	See RBRVS Schedule
90837-PS	Psychotherapy by Psychiatrist	60 min	See RBRVS Schedule

Procedure Code	Description	Unit	Rate
90853	Group Psychotherapy	per visit	See RBRVS Schedule
90785-NP	Interactive Complexity by Nurse Practitioner	15 min	See RBRVS Schedule
90785-MH	Interactive Complexity by LCPC/LCSW	15 min.	See RBRVS Schedule
90785-MD	Interactive Complexity by Physician /Addictionologist	15 min	See RBRVS Schedule
90785-PS	Interactive Complexity by Psychiatrist	15 min	See RBRVS Schedule
99201-NP	Office/Outpatient Visit–New Patient by Nurse Practitioner	10 min	See RBRVS Schedule
99201-MD	Office/Outpatient Visit–New Patient by Physician /Addictionologist	10 min	See RBRVS Schedule
99201-PS	Office/Outpatient Visit–New Patient by Psychiatrist	10 min	See RBRVS Schedule
99202-NP	Office/Outpatient Visit–New Patient by Nurse Practitioner	20 min	See RBRVS Schedule
99202-MD	Office/Outpatient Visit–New Patient by Physician /Addictionologist	20 min	See RBRVS Schedule
99202-PS	Office/Outpatient Visit–New Patient by Psychiatrist	20 min	See RBRVS Schedule
99203-NP	Office/Outpatient Visit-New Patient Nurse Practitioner	30 min	See RBRVS Schedule
99203-MD	Office/Outpatient Visit–New Patient by Physician/Addictionologist	30 min	See RBRVS Schedule
99203-PS	Office/Outpatient Visit–New Patient by Psychiatrist	30 min	See RBRVS Schedule
99204-NP	Office/Outpatient Visit–New Patient by Nurse Practitioner	40 min	See RBRVS Schedule
99204-MD	Office/Outpatient Visit–New Patient by Physician/Addictionologist	40 min	See RBRVS Schedule
99204-PS	Office/Outpatient Visit–New Patient by Psychiatrist	40 min	See RBRVS Schedule
99205-NP	Office/Outpatient Visit–New Patient by Nurse Practitioner	50 min	See RBRVS Schedule
99205-MD	Office/Outpatient Visit–New Patient by Physician/Addictionologist	50 min	See RBRVS Schedule
99205-PS	Office/Outpatient Visit–New Patient by Psychiatrist	50 min	See RBRVS Schedule
99211-NP	Office/Outpatient Visit–Established Patient by Nurse Practitioner	5 min	See RBRVS Schedule
99211-MD	Office/Outpatient Visit–Established Patient by Physician/Addictionologist	5 min	See RBRVS Schedule
99211-PS	Office/Outpatient Visit–Established Patient by Psychiatrist	5 min	See RBRVS Schedule
99212-NP	Office/Outpatient Visit–Established Patient by Nurse Practitioner	10 min	See RBRVS Schedule
99212-MD	Office/Outpatient Visit–Established Patient by Physician/Addictionologist	10 min	See RBRVS Schedule
99212-PS	Office/Outpatient Visit–Established Patient by Psychiatrist	10 min	See RBRVS Schedule
99213-NP	Office/Outpatient Visit–Established Patient by Nurse Practitioner	15 min	See RBRVS Schedule
99213-MD	Office/Outpatient Visit–Established Patient by Physician/Addictionologist	15 min	See RBRVS Schedule

Procedure Code	Description	Unit	Rate
99213-PS	Office/Outpatient Visit–Established Patient by Psychiatrist	15 min	See RBRVS Schedule
99214-NP	Office/Outpatient Visit–Established Patient by Nurse Practitioner	25 min	See RBRVS Schedule
99214-MD	Office/Outpatient Visit–Established Patient by Physician/Addictionologist	25 min	See RBRVS Schedule
99214-PS	Office/Outpatient Visit–Established Patient by Psychiatrist	25 min	See RBRVS Schedule
99215-NP	Office/Outpatient Visit–Established Patient by Nurse Practitioner	40 min	See RBRVS Schedule
99215-MD	Office/Outpatient Visit–Established Patient by Physician/Addictionologist	40 min	See RBRVS Schedule
99215-PS	Office/Outpatient Visit–Established Patient by Psychiatrist	40 min	See RBRVS Schedule

RBRVS Schedule can be found at https://medicaidprovider.mt.gov

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? (●) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

Montana would like TA to better align the State Health Improvement Plan, newly implemented OGSM and block grant priorities as they relate to MHBG, SABG and other federal contracts

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12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	(•) Yes ( ) No
3.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
4.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

none at this time

Please indicate areas of technical assistance needed related to this section.

None at this time

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

MT is currently implementing a Medication for Opioid Use Disorder (MOUD) in Emergency Departments across MT, through a planning grant. Currently 11 hospitals are involved in this project and receiving training and technical assistance on integrating behavioral health into the ED.

MT is currently implementing the same pilot project into MT Detention Centers beginning Fall 2021. An Request for Proposal (RFP) is currently taking applications for this project.

Please indicate areas of technical assistance needed related to this section.

No TA requested at this time

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** ☑ Methadone
- **b)** ☑ Buprenophine, Buprenorphine/naloxone
- **c)** ☑ Disulfiram
- **d)** ☑ Acamprosate
- **e)** ☑ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

The SOR grant is supporting expansion and enhancement of Medication for Opioid Use Disorder (MOUD) services in MT within behavioral health and healthcare settings. As of August 2021, MOUD services are beginning in several Emergency Departments around MT and collaborations with detention centers around MOUD are continuing. These federal funds support extensive academic training to Waivered providers and their care teams to support access to all FDA Approved medications, care coordination and client outcome data, all not currently reimbursable under Medicaid.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved*

medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☐ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Montana has developed a Behavioral Health Crisis System Strategic Plan that seeks to leverage multiple funding sources to develop the Crisis Now model within the state. Montana is actively involved in several program development and technical assistance initiatives, including the implementation of 988, the development of a mobile crisis response Medicaid benefit, the development of crisis receiving and stabilization facilities, the development of a bed board, increasing utilization of Certified Behavioral Health Peer Support Specialists in crisis services, and the development of a public-facing crisis system data dashboard.

Please indicate areas of technical assistance needed related to this section.

Montana would benefit from learning how other states have increased peer services within the crisis continuum. Montana would also benefit from learning how to implement standardized crisis assessments to receive accurate and timely reporting of crisis service utilization

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The state provides supportive housing and supported employment services to individuals who meet specific risk criteria. These services are community supports. Individuals with SMI including youth 16 and up (with SED) are eligible for supported employment services. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) research, about 70 percent of adults with serious mental illnesses desire work. (Mueser et al., 2001; Roger et al., 2001). Supported Employment, also known as the Individual Placement and Support (IPS) model has been proven effective in at least 27 randomized, controlled trials. The 1115 MTP waiver provides supportive housing support services to assist individuals obtain and maintain housing using SAMHSA's evidence-based practice permanent supportive housing. Both Supportive Housing and Supported Employment Services are available to individuals with SMI and SUD conditions.

To help ensure and improve upon the quality of these services, the state regularly takes part in the fidelity review process. These reviews embody a learning collaborative approach to improving the quality of the supported employment services. MHBG funds have played a pivotal role in paying for agencies to send staff to participate on reviews, as well as provide review of their services. These reviews present providers with the opportunity to learn and share best practices with other providers in the network.

To support providers, the state has launched one round of grants to assist with the infrastructure necessary to join the current supported employment services. Due to COVID, to date the state has two provider organizations with a focus on individuals with SMI and/or SUD. In late 2021, the state will begin to re-issue an RFP for additional new providers.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The AMDD administers the Block Grant, a System of Care designed for individuals who are not eligible for Medicaid or other funding sources and have a family income that does not exceed 200% of the Federal Poverty Level. In order to serve those individuals most in need of SUD treatment and prevention services, a framework provided through our State Approved SUD Treatment Programs deliver and assure effective and efficient use of our resources. To be effective and responsive, the recovery-oriented system is required to be infused with a holistic approach of sustainable recovery throughout the care provided to individuals. This assures services focus on engaging and holistic individualized integrated care that produces sustainable recovery outcomes.

5. Does the state have any activities that it would like to highlight?

Including multiple stakeholder-involvement, discussions that result in a vision of how to move our care system into a more recovery-oriented system that provides a holistic approach to an individual's needs and that it is easier to get the care needed more quickly. While it will take some time to implement the changes and require approval of some of the new services brought forth, including Peer Support services, Montana is thrilled and hopeful about the progress that has been made.

Please indicate areas of technical assistance needed related to this section.

Not at this time.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	( ) Yes (•) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

None at this time.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Recovery-Oriented Cognitive Therapy (CT-R)
In 2019, Montana was one of six states to win a Transformation Technology Initiative grant from the National Association of Mental Health Program Directors to introduce recovery-oriented cognitive therapy (CT-R) into mental health services in the state of Montana. The primary aims of the training were to enhance the skill set of Montana State Hospital (MSH) and community staff at various levels of training and experience, improve outcomes of individuals with serious mental illness, while additionally promoting and improving continuity of care, breaking the cycle of discharges and recommitments to MSH.
MSH collaboration was multisector and included hospital leadership in addition to community mental health centers who provide Program of Assertive Community Treatment (PACT), three Projects for Assistance in Transition from Homelessness (PATH) teams, two Intensive Community-Based Rehabilitation (ICBR) group home providers, Montana chapter of the National Alliance on Mental Illness (NAMI) and Montana Peer Network and Recovery Coaches/Peer Support Specialist.
Montana contracted with the Aaron Beck Center with the University of Pennsylvania to provide both CT-R workshops as well as Train-the-Trainer workshops to staff at MSH and select community providers. This training was so well received that Montana expanded the contract with the Aaron Beck Center to provide three additional workshops and Train-the-Trainer workshops in Missoula, Bozeman, and Billings.

7. Does the state have any activities related to this section that you would like to highlight?

Youth in Foster Care

The Montana Foster Care Independence Program (MCFCIP) is a part of the CFSD. The services offered by the MCFCIP are intended to help MT foster youth get the life skills they need to make a successful transition into adulthood. By assisting youth in achieving self-sufficiency and obtaining future goals, the MCFCIP enables youth in the foster care system create a healthy lifestyle and a successful future.

Services offered:

• Life skills instruction;
• Educational/Vocational Assistance;
• Transitional living plans;
• Life skills assessments;
• Mentors; and
• Youth Advisory Board.

Assistance with:

• Obtaining a graduation equivalency degree, or HiSet;
• Obtaining a high school diploma;
• Accomplish other educational achievements;
• Acquiring volunteer experience;
• Satisfactory school performance;
• Enrolling in life skills groups;
• Enrolling in other activities intended to increase life skills and employability; and
• Obtaining full- or part-time employment.

Stipends available for youth ages 14 to 21 whose transitional living plans indicate they need help paying for:

• Secondary school educational expenses, such as tuition, tutoring, books, or driver's education.
• Vocational training, including apprenticeships.
• Job readiness assistance, such as preparing a resume, buying appropriate interview clothing, haircuts: and
• Travel costs to school or job sites.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

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Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**0**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Behavioral Health Advisory Council engages in quarterly discussions on both the MHBG and SABG priorities, indicators and funding breakdown. In FY22, the BHAC will begin meeting bi-monthly and will be involved in reviewing the responses to each environmental section of the report, as well as the Planning Steps.

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22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	(•) Yes ( ) No
b)	Posting of the plan on the web for public comment?	(•) Yes ( ) No
	If yes, provide URL: https://dphhs.mt.gov/amdd/	
c)	Other (e.g. public service announcements, print media)	(•) Yes ( ) No

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23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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