BEHAVIORAL HEALTH SYSTEM FOR FUTURE GENERATIONS (BHSFG)

Recommendation 8: Implement a Care Transitions Program

The Department of Public Health and Human Services (DPHHS), as part of the BHSFG initiative, is launching a three-year Care Transitions pilot program to support people leaving the Montana State Hospital (MSH) in achieving greater stability, improved quality of life, and better long-term outcomes in the community, while reducing avoidable readmissions. The program will be grounded in Critical Time Intervention (CTI) and developed with technical assistance from the Center for the Advancement of CTI (CACTI). Services will be delivered by DPHHS staff in alignment with CTI principles, and the program will provide structured support beginning before discharge and continuing throughout the return to community life, helping individuals build durable connections to treatment, services, and natural supports that matter to them.

CTI is person-centered, evidence-based, and trauma-informed, using a "coaching" style of intervention to build self-reliance. It prioritizes connection to durable community supports and directly addresses social determinants of health (SDOH) that influence engagement and stability. The model complements and does not replace existing supports. CTI interventions fall between Targeted Case Management (TCM) and Assertive Community Treatment (ACT) in intensity.

WHY CTI FOR MONTANA STATE HOSPITAL

- Transition from inpatient to community is a vulnerable period
- Opportunity to improve continuity of care and long-term stability
- Aligns with statewide goals for recovery-oriented, person-centered systems of care and outcomes

ABOUT THE CTI MODEL

CTI is a Case Management-derived service that centers around a major life transition. CTI is delivered as a phased, time-bound sequence that decreases over time according to individual need. CTI begins prior to discharge with in-person meetings with individuals at MSH. The model provides the highest level of support immediately after discharge and then gradually steps down as connections to long-term providers and natural supports strengthen. The phases below outline the typical cadence, activities, and duration.

- **Phase 0 (Engagement and Planning):** 2–4 weeks before discharge. Meet in person; establish rapport; confirm eligibility and voluntary participation; identify priority needs and goals; map supports; build the transition plan with the person and their providers/natural supports; begin preparing for the individual's return to the community.
- **Phase 1 (Transition):** Months 0–3 post-discharge. High-intensity support. Frequent in-person contacts; warm handoffs to community providers; rapid problem-solving around housing, benefits, medications, appointments, transportation, and crisis planning; reduce barriers to supports, including transportation and SDOH-related barriers; mapping strengths and resources.
- **Phase 2 (Try-Out):** Months 4–6. Moderate-intensity support. The person practices using their support network and services with CTI Worker coaching; troubleshoot gaps; refine the support plan; and transfer responsibilities to long-term providers and natural supports.

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- **Phase 3 (Transfer of Care):** Months 7–9. Lower-intensity support. Solidify roles of community providers and natural supports; confirm reliable follow-up and contingency plans; and step down CTI contacts as the person maintains stability.
- **Closeout:** Final handoff and review. Ensure the person understands their plan, contacts, and crisis pathways; complete outcomes review and documentation; review successes and celebrate graduation.

PROGRAM STRUCTURE AND STAFFING

The Care Transitions program staff will be DPHHS employees and will be comprised of CTI Workers and a Clinical Supervisor. CTI workers will be based in designated target communities and will be the primary, field-based staff supporting individuals through the transition from hospital to community—engaging people prior to discharge, coordinating warm handoffs, and coaching on practical skills that support stability. A Clinical Supervisor will provide clinical oversight and supervision, ensure adherence to CTI fidelity, and lead routine case consultation and field-based coaching.

TARGET POPULATION, COMMUNITIES, AND PHASED IMPLEMENTATION

The target discharge communities were selected based on admission volume, with a focus on length of stay (i.e., 90 days or less), readmissions occurring within nine months, and high rates of readmission (i.e., more than three admissions within two years). In addition, the individuals must be discharging to a pilot community.

Pilot Phase 1 (Year 1):

- Missoula County
- Yellowstone County
- Silver Bow County
- Gallatin County

Pilot Phase 2 (Years 2–3): Two of the following counties:

- Glacier County
- Flathead County
- Cascade County
- Lewis and Clark County

Staffing will ramp over the three-year pilot. In Year 1, one CTI Worker will be placed in each Phase 1 community, for a total of four. In Year 2, a fifth CTI Worker will be added as the first Phase 2 community launches. In Year 3, a sixth CTI Worker will be added with the second Phase 2 community, bringing the total to six across six communities.

PROGRAM STATUS AND NEXT STEPS

The pilot program is anticipated to begin accepting clients in July 2026. Implementation work is underway to ensure a smooth launch and early fidelity to the model, including hiring CTI Workers and supervisory staff; developing workflows, training, and fidelity-aligned practices; planning for data collection and outcome analysis (e.g., readmissions, engagement, and SDOH stability); and coordinating with hospital and community partners to establish referral pathways and warm handoffs.