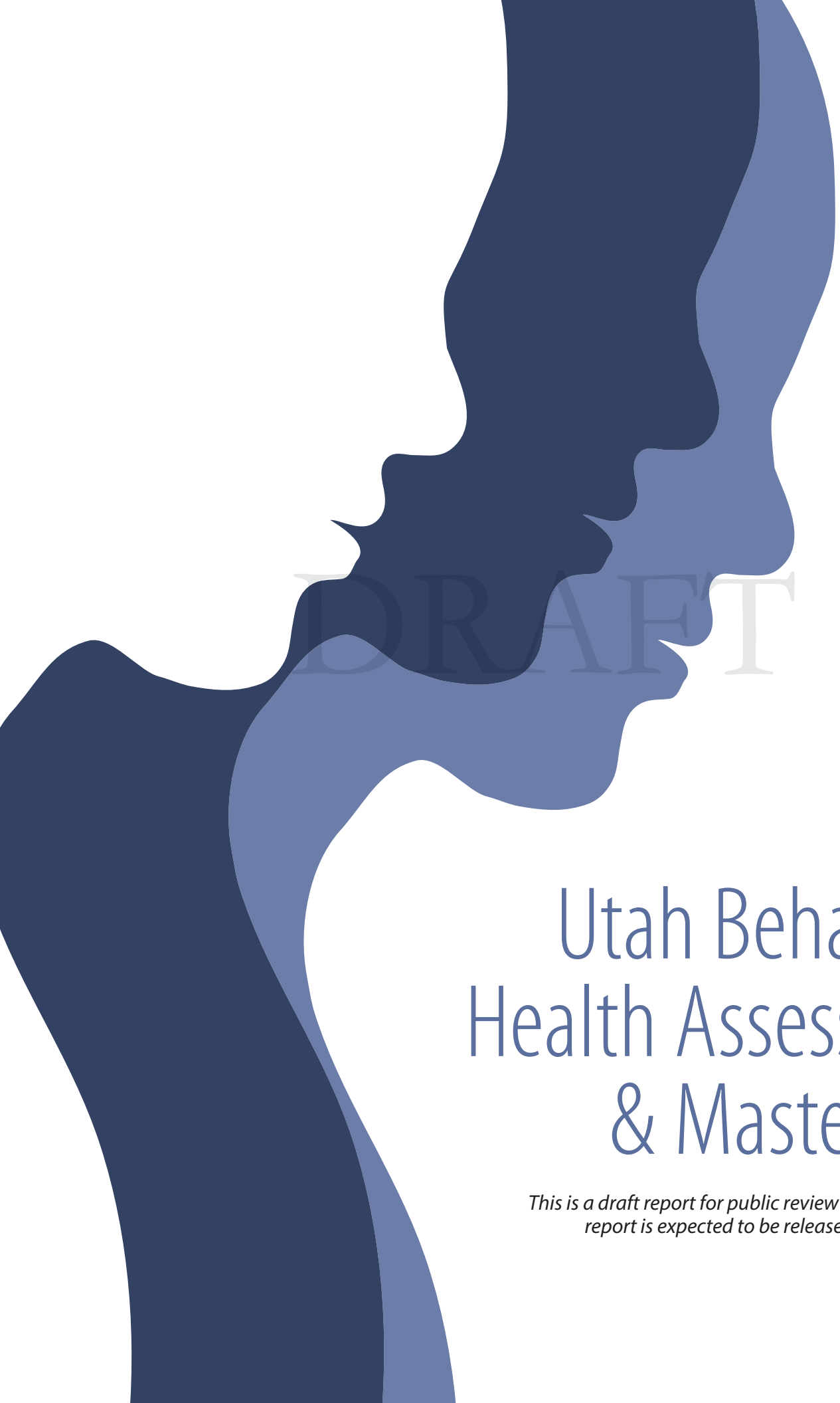


Utah Behavioral Health Assessment & Master Plan

This is a draft report for public review and feedback. A final report is expected to be released in September 2023.

July 2023

Shared Vision

The vision of the Utah Behavioral Health Coalition is to improve equitable access to high-quality behavioral health services and supports for all Utahns.

Utah Behavioral Health Coalition Members

Tammer Attallah
Intermountain Health

Greg Bell
Utah Hospital Association

Nate Checketts
Utah Department of Health and Human Services

Adam Cohen
Odyssey House of Utah

Rebecca Dutson
The Children's Center Utah

Steve Eliason
Rep. Utah House District 43

Janida Emerson
Fourth Street Clinic

Patrick Fleming
Utah Substance Use and Mental Health Advisory Council (USAAV+)

Brandon Hatch
Davis Behavioral Health

Melissa Huntington
Four Corners Community Behavioral Health

Brent Kelsey
Office of Substance Use and Mental Health

Liz Klc
Utah Substance Use and Mental Health Advisory Council (USAAV+)

Kimberly Myers
Intermountain Health

Mark Rapaport
Huntsman Mental Health Institute

Jordan Sorenson
Utah Hospital Association

Eric Tadehara
Office of Substance Use and Mental Health

Doug Thomas
Intermountain Health

Mason Turner
Intermountain Health

Ross Van Vranken
Huntsman Mental Health Institute

Utah Hospital Association Behavioral Health Committee
Chair: Jeremy Cottle

Utah Department of Health & Human Services

UHA Utah Hospital Association

Kem C. Gardner Policy Institute, The University of Utah, David Eccles School of Business

Leavitt Partners, An HMA Company

The Utah Behavioral Health Coalition

Behavioral health is an essential component of every Utahns' health and well-being.

When people have better behavioral health, they are healthier, happier, and more productive—positively impacting communities, safety, and the economy. Utah is invested in creating a comprehensive and coordinated approach to improve people's behavioral health by enhancing equitable access to behavioral health services, eliminating gaps, and implementing system changes to drive outcomes.

To accomplish these objectives, the Utah Behavioral Health Coalition came together to better understand and assess the state's current system of behavioral health services and supports and develop a Master Plan for improvement. This process includes:

1. Conducting an environmental scan to understand current behavioral health initiatives; challenges, barriers, inequities, and needs related to providing and accessing behavioral health services in Utah; and the changing and future needs of relevant stakeholders connected to Utah's behavioral health system.

2. Assessing the information, data, and feedback collected during the environmental scan to identify system-level gaps, key areas of need, and possible recommendations utilizing both a top-down and bottom-up approach to system-level reform.

3. Drafting a Master Plan that can serve as a guide for state, private, and public stakeholders striving to create more aligned and efficient behavioral health systems for the state of Utah that provide timely access to high-quality care across a comprehensive continuum of behavioral health services and supports.

Contents

Introduction

Utah is working to address a growing behavioral health crisis. While the state is leading the nation on many behavioral health innovations, interventions, and reforms, high suicide rates, untreated anxiety and depression, serious mental illness, and drug-related deaths are all signs of the need for more accessible, aligned, and efficient behavioral health services.

58%

of children in Utah with a clinically diagnosed mental or behavioral health condition did not receive treatment or counseling.

Access

Unfortunately, many Utahns do not have access to the care they need. While data show access may have improved for some populations, nearly half of Utah's adults and youth with mental health needs do not receive services or treatment.[1] For example, 58% children ages 3-17 in Utah with a clinically diagnosed mental or behavioral health condition did not receive treatment or counseling (2020-2021).[2] Among children who need treatment, 40% of parents report that services are difficult or, sometimes, impossible to obtain.[3]

The share of adults ages 18 or older with any mental illness (AMI) that received mental health services is 49.8% (2017–2019). This represents a 7.9 percentage point increase from 2008–2010, indicating access has improved. However, close to 50% of adults are still not receiving treatment.[4] A 2023 survey issued by the Office of Professional Licensure Review found the average wait time for outpatient behavioral health services in Utah is slightly over two months, while the recommended guideline is generally 10 business days. A limited number of rural, language accessible, and culturally literate behavioral health providers makes access even more difficult for these communities.

Behavioral health is a high priority for Utahns. Mental health was one of the most discussed topics during recent meetings where Utahns highlighted the health needs of their community[5] and more than half of Americans say mental health is the biggest health problem facing our country.[6]

Nearly **50%** of adults in Utah with a mental illness are not receiving treatment.

More than half of Americans say **mental health** is the **biggest health problem** facing our country.

Workforce Shortages and Gaps in Care

Behavioral health needs in Utah currently outweigh the supply of services and supports. Utah has mental health provider shortages in every county and has fewer mental health providers per 100,000 people than the national average.[7]

Pressures on Utah's limited workforce were amplified by the COVID-19 pandemic, with mental health providers reporting a 20% median increase in caseloads since April 2020.[8] This is reflected in national numbers with nearly half of adults ages 18 or older with serious mental illness (SMI) feeling the COVID-19 pandemic negatively impacted their mental health.[9]

Numerous gaps in care exist across Utah's continuum of behavioral health services and supports,[10] in rural and culturally diverse communities, as well as across the population lifespan (from infant and early childhood to older adults). Improving Utah's behavioral health system requires expanding Utah's behavioral health workforce and services and supports to address these gaps, particularly for individuals with crisis and complex behavioral health needs.

Utah's mental health providers reported a

20%

increase in caseloads since the start of the COVID-19 pandemic in April 2020.

"We cannot continue to do the same things in terms of treatment, workforce, and access if we want to move the needle."

Need for System-Level Coordination and Innovation

An assessment of Utah's behavioral health system indicates system fragmentation limits the ability to access the right care at the right place and at the right time. For example, behavioral health services are often bifurcated across different delivery systems making it more difficult to consistently and efficiently deliver integrated care. Many primary care providers lack the training and resources to engage in behavioral health screenings, early intervention, and treatment of mild-to-moderate behavioral health conditions. Limited reimbursement for both public and private behavioral health services can also be a barrier to providing and accessing services.

An increasing number of siloed systems, such as self-pay (or cash-only) providers, further divides the system. This siloing creates additional challenges with equitable access, accountability, transparency, and monitoring the quality and efficacy of services provided. Some national studies estimate that only a portion of persons receiving behavioral health care benefit from treatment received.[11, 12]

Utah's behavioral health system needs more focus on prevention, early intervention, and coordinating points of access by better integrating physical and behavioral health care. A focus on improving care quality—utilizing evidence-based treatment and measurement-based care—would also help address Utah's growing behavioral health crisis.

Benefit of Addressing Behavioral Health

Utah's experience is part of a national problem, where depression is estimated to cause 200 million lost workdays each year, and SMI results in $193.2 billion in lost earnings.[13] Depression is a leading cause of disability nationwide[14] and national cost estimates of mental, emotional, and behavioral disorders among youth amount to $247 billion per year in mental health and health services, lost productivity, and crime.[15] This increases costs to other sectors such as public and private health systems, corrections, criminal justice, housing, and child welfare.[16, 17]

Investing in and improving access to high-quality behavioral health services can help reduce or neutralize costs across public and private health systems and sectors such as education, corrections, criminal justice, housing, and child welfare.[18] More importantly, investing in and improving access to high-quality behavioral health services saves lives.

Mental, emotional, and behavioral disorders among youth amount to

$247 billion

per year in mental health and health services, lost productivity, and crime.

Key Findings from the Assessment

Under the direction of the Utah Hospital Association (UHA) and the Utah Department of Health and Human Services (DHHS), the Kem C. Gardner Policy Institute and Leavitt Partners, a Health Management Associates company (LP/HMA), are assisting the Utah Behavioral Health Coalition assess needs, gaps, and challenges in Utah's behavioral health system. This assessment informed the development of the Master Plan, which can serve as a guide for state, private, and public stakeholders striving to create more aligned and efficient behavioral health systems for the state of Utah.

As part of this process, the Gardner Institute and LP/HMA conducted 30 formal discussion groups and in-depth interviews from June 2022 to January 2023. The Gardner Institute continues to engage in additional informal interviews with groups and individuals that are interested in more targeted discussions about current initiatives and concerns.

An assessment of the information and feedback collected during the environmental scan indicates that six system-level issues are creating and exacerbating gaps and challenges in Utah's behavioral health system. These system-level issues are interconnected and impact providers and services across Utah's continuum of behavioral health services and supports (Figure 1) for all persons across the population lifespan (from infants and young children to older adults).

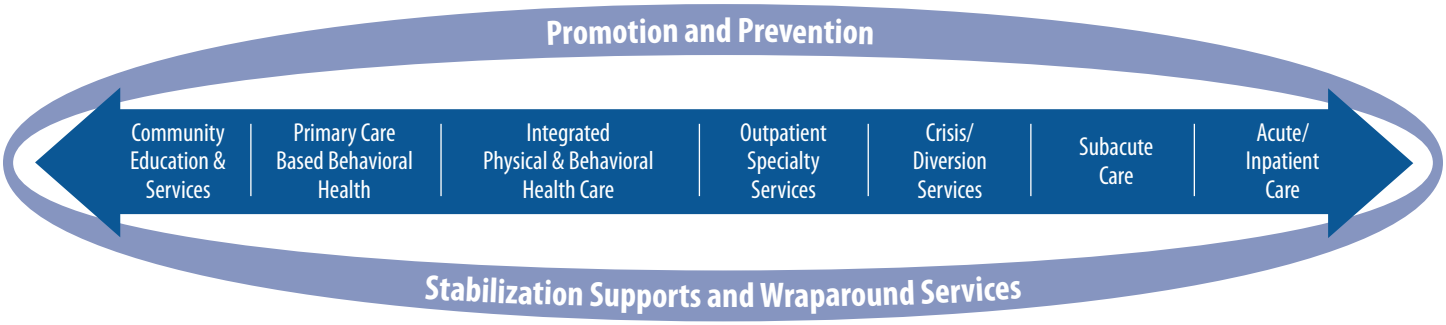
An overview of the six system-level issues is provided below. Detailed findings from the environmental scan highlight how these issues impact different components of the continuum (see "Environmental Scan: Detailed Findings"). The Detailed Findings section also provides information from the discussion groups and interviews on additional gaps and barriers to providing and accessing behavioral health services and supports.

Discussion Group Details: Over 30 groups and close to 300 participants

- 30 discussion groups and in-depth interviews held from June 2022 to January 2023, as well as many additional informal interviews.
- Close to 300 participants were engaged across the groups and interviews.
- Discussion group and interview participants comprise a diverse range of stakeholders involved in or connected to Utah's behavioral health system, including representation from:
  - Persons with lived experience (serve on USAAV+ subcommittees)
  - Community providers (local authorities, community health centers, federally qualified health centers)
  - Homeless service providers
  - Private providers (nonprofit providers, pediatricians, family care practice physicians, clinical practitioners, behavioral health treatment providers, psychiatrists, and residential and institutional providers)
  - Payers (representatives from Utah's Medicaid Accountable Care Organizations (ACOs), the state's health insurance plan (PEHP), private health insurance companies, and high-deductible health plans (HDHPs))
  - Providers of health promotion and prevention services (local and state coalitions as well as local authorities)
  - Crisis services
  - Recovery and treatment supports
  - Health systems
  - State agencies, including representatives from the Department of Health and Human Services, Department of Workforce Services, Department of Insurance, the Utah State Board of Education (USBE), Department of Corrections, Utah State Courts, Utah's Attorney General's Office, among others.
  - Education (both K-12 and higher education institutions)
  - Court, criminal, and juvenile justice systems
  - Employer representatives

Note: In this report, the term "behavioral health" describes both mental health conditions and substance use disorders (SUD), unless otherwise specified. When mental health conditions or SUDs are separate, the report uses the term "mental health" or "SUD." More definitions are in Appendix: Acronyms & Definitions.

Figure 1: Utah's Continuum of Behavioral Health Services and Supports



Note: This continuum was developed as a part of the 2020 Roadmap for Improving Utah's Behavioral Health System.
Source: Utah Hospital Association

Silver Linings

While the findings from the environmental scan and the system-level issues primarily focus on what could be improved within Utah's behavioral health system, it is important to recognize that there are a lot of positives.

It is not possible to mentioned all the positives in this report, but it is clear that:

- Utah's leaders, including the Governor and Legislature, understand the importance of addressing Utah's behavioral health needs.
- Utah's behavioral health community is passionate about addressing these needs. There is also a growing number of sectors and stakeholders invested in improving Utah's behavioral health, including employers.
- There is a desire to meet people where they are and provide services that are easily accessible.
- Utah is leading the nation on many behavioral health innovations and reforms (e.g., SafeUT, 988, development of Utah's comprehensive crisis system, supported employment, etc.).
- There are examples of successful coordination at the local level.

1 A lack of system-level coordination and a unified approach to behavioral health

Findings from the environmental scan indicate a strong need to improve system-level coordination between all sectors, systems, and stakeholders involved in Utah's behavioral health system. These include, but are not limited to public and private mental health and substance use disorder (SUD) systems and providers, public and private physical health systems and providers, Medicaid and private health insurance plans (both commercial and self-funded), housing and homeless services, child welfare, services for persons with disabilities, K-12 schools, higher education, the court systems and criminal justice (including corrections and law enforcement), etc.

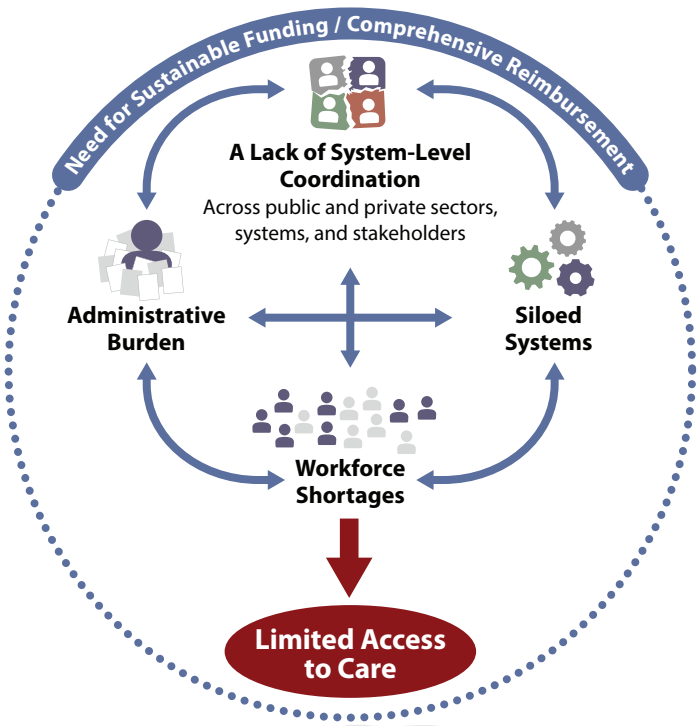
The lack of system-level coordination extends beyond payer- and provider-level integration. It stems from an increasing number of state agencies, health systems, public and private providers, payers, schools, nonprofit organizations, and advocates addressing behavioral health issues in positive ways with initiatives that are needed, well-intentioned, and often well-designed—but often doing so in an uncoordinated way.

In general, discussion groups noted a need for better linkages or connecting points between the:

- Different sectors, systems, and stakeholders connected to Utah's behavioral health system
- Different sections on the continuum of behavioral health services and supports
- Different initiatives and groups working within each section

A lack of system-level coordination increases fragmentation and complexity of the behavioral health care delivery system, creating challenges and potentially reducing quality for Utahns seeking behavioral health care. As noted above, system-level fragmentation leads to the development of an increasing number of "siloed" initiatives and systems and administrative burdens for providers. This creates challenges with transition support and patient navigation and contributes to the state's access issues. The lack of a coordinated system also means public funds are not being maximized for efficiency or effectiveness.

Figure 2: Utah's Behavioral Health System-Level Issues



Source: Kem C. Gardner Policy Institute

2 Administrative burdens

A common theme heard across multiple provider and services-based discussion groups was the need to reduce the administrative burden placed on behavioral health treatment, service, and support providers. While a large part of this burden comes from federal rules, regulations, and reporting requirements, part of it stems from a lack of administrative standardization or simplification (where possible) that could be improved through better system-level coordination.

For example, one discussion group noted that providers can have up to 20 different behavioral health contracts with the state alone, all of which have different contract, reporting, and documentation requirements. Other discussion groups noted the difficulty of having to navigate through multiple contracts and manuals to determine what services may be covered for a patient depending on the patient's eligibility (if in the public system) or health insurance plan (if in the private system). The administrative complexities associated with licensing and certification were also mentioned as a challenge.

It was suggested that these administrative burdens are resulting in workers leaving the state's public behavioral health system and that an increasing number of providers are also not paneling with private health insurance companies because of the complexity of credentialing and seeking reimbursement.

3 Siloed systems

Having multiple behavioral health administrative and service delivery systems contributes to well-intentioned but often siloed approaches to addressing system needs. Some of these initiatives stem from the desire to attend to specific behavioral health needs of certain populations, and others are emerging as alternatives to administratively complex public and private systems. However, when these efforts are developed or implemented without coordination or consideration of their impact on the larger behavioral health system, they can result in increased challenges, inefficiencies, and lost opportunities for broader positive impact. As noted by one discussion group participant:

"This country's behavioral health system is based on an ad hoc approach to system development. It has been decades of organized chaos."

Some of the main concerns with these siloes are that they:

- Create challenges with accountability, transparency, and monitoring the quality and efficacy of services being provided.
- Are not always connected back into the broader behavioral health system (limiting referrals to other services and supports patients may need, limiting the ability to support transitions within the system, and complicating patient navigation).
- Duplicate services in a system that is already under-resourced.
- Exacerbate workforce shortages by creating systems of unconnected mental health and SUD service providers.

Some of these siloes may be contributing to less access overall as well. For example, the growing number of providers that are moving to self-pay (or cash-only payments) to avoid the complexities of working with public and private payers leads to system fragmentation, makes it difficult for the state and private health insurance plans to contract with a sufficient number of providers to meet the state's growing behavioral health needs, further reduces the ability to integrate physical and behavioral health, and creates a system where more people have to pay out-of-pocket to access necessary services. This limits access to care and leads to additional inequities for populations that are unable to pay cash for services.

Building better bridges or connecting points between these siloed systems can help improve system-level efficiencies and help ensure access to a full continuum of behavioral health services and supports.

Office of Professional Licensure Review: Behavioral Health Licensure Review

The Office of Professional Licensure Review (OPLR), within the Utah Department of Commerce, is engaged in a comprehensive review of mental and behavioral health licenses in Utah. Key findings from their review align with and support findings from the environmental scan including:

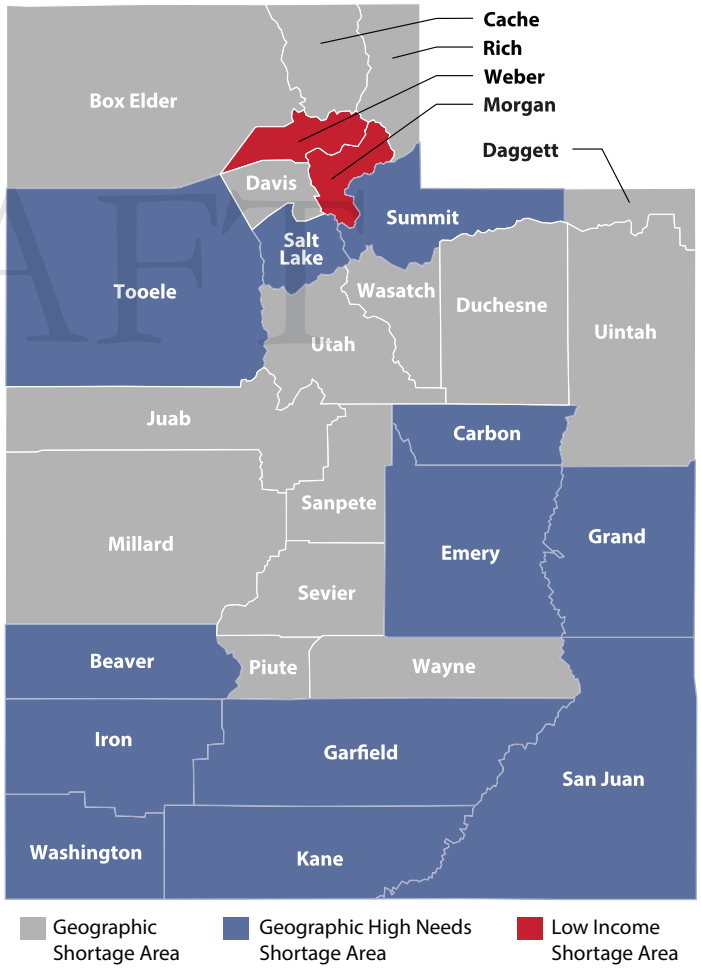
1. Utah has a behavioral health access problem, which partially stems from workforce capacity issues. For example, OPLR found there are about 16,600 licensed behavioral health workers in Utah but given some of these persons are not working, or working outside of Utah, and that around 38% of Utah's behavioral health workforce is only working part time, this translates to a significant reduction in workforce capacity.
2. OPLR also found that around 38% of behavioral health work hours are not spent in direct patient care, which further reduces the workforce.
3. Access appears to be worse in outpatient care settings, privately funded care (e.g., commercial insurance and self-pay), and for psychological services. For example, a survey issued by OPLR in 2023 found the average wait time for outpatient behavioral health services in Utah is slightly over two months, while the recommended guideline is generally 10 business days. The average wait time for inpatient services is slightly less than one month.
4. The proportion of practitioners accepting private insurance is lower than the proportion of consumers covered by private insurance—and self-pay providers appear to be filling this gap. Full self-pay is accepted by 60% of all behavioral health practitioners in OPLR's survey and 85-90% of independent practitioners.
5. There are concerns with the quality and safety of Utah's behavioral health system. Utah ranks poorly (49th relative to other states) on the number of adverse action reports per behavioral health worker, a key measure of safety for behavioral health.

4 Workforce shortages

Discussion groups frequently mentioned Utah's ongoing—and growing—behavioral health workforce shortages as a challenge that is disrupting care across the continuum of behavioral health services and supports. Workforce shortages seem to impact all points along the service continuum, impact all areas of the state, and span all provider specialties. The limited number of rural, language accessible, and culturally literate behavioral health providers was specifically noted as well.

Workforce shortages associated with outpatient specialty care impacts the ability to prevent a person's behavioral health issues

Figure 3: Type of Mental Health Care Professional Shortage Area by County (Geographic, High Need, or Low Income), 2022



Note: Mental health shortages are determined across three different domains. (1) Geographic, meaning a shortage of providers for the entire population within a defined geographic area. (2) Geographic High Needs, meaning at least 20% of the population has income below 100% FPL, there is a high ratio of children or elderly in the population, there is a high prevalence of alcoholism, or there is a high degree of substance use disorders. (3) Population groups, meaning there is a shortage of providers for specific population groups within a defined geographic area (e.g., low-income individuals).

Source: Utah Office of Primary Care and Rural Health

from worsening, as well as provide sufficient services to discharge people from high-acuity services and link them to community-based care.

As noted above, Utah's workforce shortages are exacerbated by a lack system-level coordination, administration burdens, and the creation of siloed and sometimes competing initiatives that may increase access for some populations but decrease access for others. Examples of how workforce shortages are being aggravated by a lack of system-level coordination, disrupting care, and limiting access are included throughout the "Environmental Scan: Detailed Findings" section.

Findings from the environmental scan also point to the need for more provider education and training in research-based practices (e.g., engaging and training primary care providers in behavioral health screenings, early intervention, and treatment of mild-to-moderate behavioral health issues); as well as more providers qualified to treat persons with co-occurring conditions (e.g., homelessness, intellectual or developmental disabilities (ID/DD), and autism spectrum disorder). Findings also point to the need to expand the behavioral health workforce to include more certified or credentialed non-licensed professionals (e.g., peer support specialists, certified case managers, community health workers (CHWs), etc.) as a potential solution to addressing Utah's workforce shortages.

5 Limited access to care

As noted above, a lack of system-level coordination (e.g., multiple behavioral health administrative and service delivery systems, siloed systems, access points, etc.) produces a complex, often confusing system for individuals seeking services. Discussion group participants confirmed that people utilizing Utah's behavioral health system often experience challenges with patient navigation and care transition support, which limits the ability to access the right care at the right place and at the right time. Workforce shortages combined with increased demand results in delays or even an inability to access behavioral health services and supports. Addressing these system-level issues can help alleviate pressures within the system, ensure demand is targeted to the right areas, improve issues with supply, and ultimately increase access.

Findings from the environmental scan indicate there are concerns with access across the continuum of behavioral health services and supports. That said, access issues seem to be more acute in Utah's rural areas, for certain populations (e.g., culturally and linguistically diverse and other historically marginalized populations), and in certain areas of the continuum (e.g., care for individuals with complex behavioral health needs).

Defining Access

The Utah Behavioral Health Coalition defines behavioral health access as the availability of person-centered, prompt, responsive, affordable, appropriate, and effective (evidence-based) behavioral health services and supports to all individuals across the population lifespan. Access is grounded in equitable and culturally responsive behavioral health promotion, prevention, early identification, and intervention as well as treatment and recovery services.

Effective access to care also attends to regional needs, community culture, and building systems that reduce the impact of social determinants of health and structural barriers to care. It promotes and supports people being active, engaged, and included in their treatment decisions.

6 Sustainable funding

Problems that arise from the system-level issues mentioned above are intensified by historically low funding levels, inadequate reimbursement, a complex patchwork of multiple funding streams with different requirements, and high levels of administrative burden in seeking reimbursement despite improvements in behavioral health care coverage due to federal parity laws. A common theme from the environmental scan is that many behavioral health services and supports in Utah lack long-term, sustainable funding.

For example, it was noted there is insufficient funding or reimbursement for prevention and early identification as well as to address the more complex needs of individuals with long-term issues (including reimbursement for stabilization supports and other wraparound services). Stakeholders also noted that current rates do not allow systems and clinics to offer competitive wages, a contributing factor to workforce shortages. Burdensome reimbursement requirements associated with eligible staff and supervision, documentation, service location, and utilization management are additional components challenging the system.

Finally, many behavioral health providers rely on time-limited grants (each with their own funding terms and restrictions) to sustain and supplement service offerings. Applying for these grants is time and resource intensive and limits the ability to provide consistent services or staffing overtime. Other examples of how sustainable funding is needed to improve access and the provision of behavioral health services are throughout the "Environmental Scan: Detailed Findings" section.

Utah's Behavioral Health Master Plan

Mission of the Master Plan

Create aligned and efficient behavioral health systems for the state of Utah that provide timely access to high-quality care across a comprehensive continuum of behavioral health services and supports.

Framework

Utah's Behavioral Health Master Plan identifies system priorities and provides a roadmap for structural and system changes. The Master Plan was drafted by the Behavioral Health Coalition and is based on the findings from the environmental scan and behavioral health assessment. It utilizes a framework that consists of the following four areas:

Figure 4: Utah Behavioral Health Master Plan Framework

Source: Leavitt Partners, a Health Management Associates Company

Guiding Principles

Three principles guide current and continued development of the Master Plan. To correct the system-level issues identified above and ensure an efficient system moving forward, reforms to Utah's behavioral health system should promote access, alignment, and value.

1. **Access:** Reforms should create equitable access to care for all Utahns that is responsive to individual, family, employer, community, and geographic need.

> A key part of access is ensuring ***"equitable access"*** or reforms that reduce behavioral health inequities, disparities, and stigma and advance health equity, diversity, inclusion, and access.

2. **Alignment:** Reforms should support aligned, navigable, comprehensive, and sustainable behavioral health services across public and private systems, payers, and sectors.

> A key part of alignment is ***"sustainable"*** or ensuring reforms support the right level of payment for different markets, different levels of care, and streamline funding and reimbursement across payers and service types to ensure providers have the resources necessary to engage in reforms.

3. **Value:** Reforms should encourage investments in effective behavioral health services and initiatives that demonstrate both direct behavioral health cost savings and indirect medical, educational, and social service cost savings.

> A key part of value is ***"effective"*** or promoting reforms that are high quality, outcomes based, and recovery focused. Improving the efficacy of care will lead to improved efficiency of care and the ability to intervene further upstream.

Strategic Priorities

1 Support the creation, innovation, and implementation of research-based interventions.

2 Strengthen behavioral health prevention and early intervention.

3 Integrate physical and behavioral health.

4 Continue to build out Utah's behavioral health crisis and stabilization systems.

5 Improve the availability of services and supports for individuals with complex behavioral health needs.

6 Expand and support Utah's behavioral health workforce.

The Master Plan's guiding principles directed the creation of six strategic priorities. These priorities are designed to reflect community feedback, achieve the mission of the Master Plan, and improve behavioral health for all Utahns across both urban and rural areas.

The Master Plan also outlines key decisions and recommended continuum changes to achieve the strategic priorities (a top-down and bottom-up approach). It is important to consider these strategic priorities, key decisions, and continuum changes as a starting point. As work begins and evolves in each of these areas, and more research is conducted, existing decisions and recommended changes may be modified, and more priorities, decisions, and recommended continuum changes will be identified.

It is also important to note that the key decisions and recommended continuum changes identified in the Master Plan align with or support multiple strategic priorities, and could therefore be organized by topic, recommended actions, or how they connect to different portions of Utah's continuum of behavioral health services and supports (Figure 1). To visualize how the information in the Master Plan can help support specific strategies, it is currently presented in a format that outlines strategic priorities, key decisions, and continuum changes as steps to system reform.

Finally, the Master Plan does not intend to dictate or oversee all activities within or connected to Utah's behavioral health system. It is meant to serve as a guide for private and public sectors, systems, and stakeholders striving to achieve the mission of ***creating more aligned and efficient behavioral health systems for the state of Utah that provide timely access to high-quality care across a comprehensive continuum of behavioral health services and supports.***

While some of the recommended continuum changes may result in state-directed or public system reform, the Master Plan is designed to call attention to high-priority areas and help facilitate the development of solutions by other sectors and private systems as well. Most people in Utah access behavioral health services in private systems and have employer-based private health insurance (Figure 17). A unified approach to system-level reform will help ensure all Utahns have better behavioral health.

Strategic Priorities: Steps to System Reform

1 Support the creation, innovation, and implementation of research-based interventions.

As noted in the environmental scan, discussion group participants feel that messaging around mental health and SUDs needs to focus more on behavioral health conditions being treatable and that "recovery is possible." Having access to high-quality and outcomes-based services can help people achieve recovery. According to the Institute of Medicine, quality health care is "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[19]

The Master Plan prioritizes strategies that support the creation, innovation, and implementation of research-based interventions. These strategies will promote a higher standard of care across public and private providers, payers (both public and employer-based plans), and systems as they commit to transparent, measurement-based care. Investing in the implementation of science-based frameworks will also help promote and sustain the delivery of evidence-based prevention, treatment, and recovery services to fidelity—and ultimately produce value for the system.

NOW

Key Decisions

- What is the role of regulatory agencies in overseeing the use of research-based treatments/interventions and monitoring patient outcomes? What resources do they need to accomplish proposed changes to their roles?
- What role does accreditation play in ensuring the use of research-based treatments/interventions that reflect the needs of populations being served (e.g., urban vs. rural)?
- What is the role of higher education, public and private health systems, and payers in identifying and promoting the use of research-based treatments/interventions?
- Should the state consider the development of an intermediary organization that supports system-wide adoption of research-based practices?

Actions

- Increase the use of valid/reliable measures that provide transparency into outcomes (e.g., Outcome Questionnaire, Functional Outcome Survey, Brief Addiction Monitor, Substance Use Recovery Evaluator (SURE),[20] etc.).
- Promote internal processes for evaluating if changes in care, treatment, or access could help prevent instances of suicide.

NEXT

Key Decisions

- How to create an equitable structure that increases transparency and holds public and private providers accountable for the effectiveness of services delivered to populations in different sectors and geographies?
- How to create an infrastructure that supports providers in providing effective, research-based interventions across systems, sectors, and geographies (e.g., training, sufficient reimbursement/ financial support, accountability structures, accreditation, etc.)?

Actions

- Use science-based definitions of evidence to inform adoption of effective treatments and interventions.
- Develop common methodologies for reporting outcomes and performance data to use across public and private systems and sectors.
- Improve access to measurement-based care grounded in a structure that increases transparency and holds public and private providers accountable for the effectiveness of services delivered to different populations in different sectors and geographies.
- Promote risk-based contracts and value-based payment arrangements that incentivize and support innovation and outcome attainment.

FUTURE

Key Decisions

- How best to financially support and sustain behavioral health innovation and the development and implementation of research-based interventions?
- How to demonstrate that cost savings from addressing behavioral health impact the entire ecosystem, and these dollars are most effectively reinvested back into behavioral health? (i.e., account for cross-sector savings from addressing behavioral health)

Actions

- Develop, build, and implement behavioral health systems that support implementation of research-based treatments/interventions across and appropriate to different provider types, populations, and geographies.
- Promote projects and initiatives across private and public payers, systems, and sectors that demonstrate overall medical, educational, and social service cost savings to ensure sustainability.

2 Strengthen behavioral health prevention and early intervention.

Effective promotion, prevention, and early intervention is critical to getting ahead of Utah's growing behavioral health needs, particularly for Utah's infants, young children, and youth. Preventing behavioral health issues in children and youth not only directly helps the child live a happier, healthier, and more productive life, but it improves the lives of their siblings and parents, and reduces impacts to the child's school. Strengthening Utah's behavioral health prevention and early intervention systems also helps to reduce mental health and SUD stigma and build resiliency and emotional flexibility. This positively impacts children, parents, and communities, which can in turn bolster protective factors, reduce risk factors, and increase productivity.

The Master Plan supports strategies that promote effective, coordinated, and community-based prevention and early intervention strategies. Expanding the general population's understanding of behavioral health and preventing or delaying the escalation of worsening behavioral health issues will help improve access by reducing the need for more acute, and costly mental health and SUD services and interventions. This places downward pressure on public and private system costs, and reduces costs in other sectors such as education, corrections, criminal justice, housing, and child welfare.

NOW

Actions

- Continue to provide mental health and SUD training and technical assistance to communities, providers, and other system stakeholders across the state (e.g., childcare and preschool providers, school counselors and other K-12 staff, law enforcement, etc.).
- Continue to support schools and other community settings by making behavioral health programming available that focuses on stigma, SUD prevention, and mental health promotion and resilience (e.g., SafeUT, the Huntsman Mental Health Institute (HMHI) Brain Health curriculum, Intermountain Health's "Talk to Tweens"[21] emotional well-being program, others, etc.)
- Expand awareness of prevention and early intervention services that can be reimbursed by public and private payers (e.g., Early and Periodic Screening, Diagnostic and Treatment (EPSDT); DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; Screening, Brief Intervention and Referral to Treatment (SBIRT), etc.).
- Continue to facilitate engagement around stigma, aligning efforts with the collaborative HMHI anti-stigma campaign to identify and address structural stigma (laws, regulations, policies), public stigma (attitudes, believes, behaviors), and self-stigma (internalized negative stereotypes). Examples are provided below.

  Structural: Enact change at the structural level by uniting elected officials, other leaders, and Grand Challenge partners to collaboratively develop platforms with measures to determine areas for change at the public and private policy level.

  Public: Create measurable change in cultural norms and attitudes to improve the awareness and acceptance of persons with mental health and SUDs.

  Self: Improve personal awareness, self-acceptance, and understanding in people impacted by mental health and SUDs, providing tools and services that enables them to empower themselves to live full lives.

NEXT

Key Decisions

- How to better integrate prevention into Utah's continuum of behavioral health services and supports?
- How to establish sustainable funding for prevention services in both urban and rural geographies?

Actions

- Explore how positive childhood experience research and models can be developed, expanded, or adopted across Utah's behavioral health system to counter the impact of adverse childhood experiences (ACEs).
- Evaluate ways to expand and improve the provision of family-based care for children, youth, and adults (e.g., use of available codes, effective models, individual and family respite services and supports, services and resources for families assisting persons with suicide ideation, etc.).
- Build structures that promote appropriate screening and identification of need with referral to indicated interventions.
- Increase funding for primary, secondary, and tertiary prevention services, including reimbursement by public and private payers.

FUTURE

Actions

- Ensure access to and reimbursement for age-appropriate and uniform screening across the state, which could also support baseline data creation and monitoring changes in need.

3 Integrate physical and behavioral health.

Improving Utah's behavioral health system requires more focus on integrating physical and behavioral health across and within public and private clinics, systems, and payers. Promoting integrated care with targeted referrals to specialty behavioral health care expands access to mental health and SUD services and helps to alleviate workforce shortages. Research shows integrated approaches address system fragmentation and close care gaps, improve care management, provide a holistic member experience, and are generally cost effective. For example, overall spending on individuals with a behavioral health diagnosis is 2-4 times higher than for individuals without a behavioral health diagnosis.[22] Improving integration between physical and behavioral health care can help reduce these costs.[23] [24]

The Master Plan identifies three areas for improving physical and behavioral health integration in Utah:

3a Increase clinical-level coordination between primary care and behavioral health providers.

3b Evaluate ways to reduce barriers and gaps in the delivery of services across public physical and behavioral health systems.

3c Encourage better alignment of integrated behavioral health across public and private payers and systems.

Increase clinical-level coordination between primary care and behavioral health providers.

Improved detection, effective management, and recovery of mild-to-moderate behavioral health conditions through increased coordination and integration between primary care and behavioral health providers can help reduce the worsening of behavioral health needs and alleviate pressure on downstream services and supports. Research shows 10–20% of the general population will consult a primary care clinician for a mental health problem in a given year, and that 10–40% of primary care patients have a diagnosable mental disorder.[25]

Clinical-level coordination is growing in Utah, and the Master Plan supports strategies that continue to increase clinical-level coordination between primary care and behavioral health providers. This includes creating regionally based referral networks to support primary care providers with clear pathways to specialty behavioral health providers for patients who need higher-level care as well as leveraging certified or credentialed non-licensed professionals as integrated care team members (see strategic priority #6).

The Master Plan also acknowledges that integrated care models vary, and different approaches should be utilized based on each health system's needs. While some specific approaches are mentioned in this report, the Master Plan supports the continued use and development of coordinated, evidence-based, and regionally appropriate models.

NOW

Actions

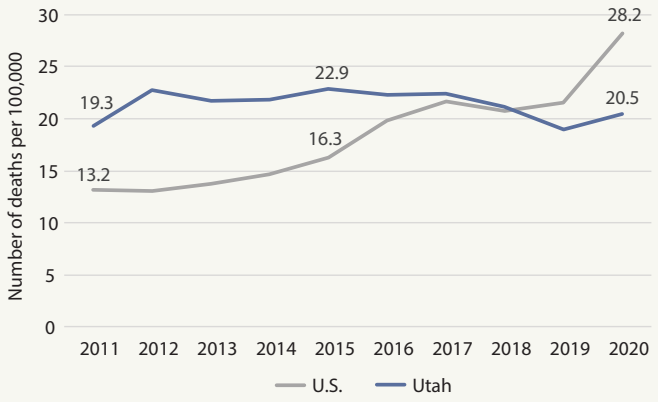
- Continue to support statewide consultation support to primary care providers (e.g., Psychiatric Consultation Program, or CALL-UP).
- Provide state-supported education, training, and technical assistance to primary care providers across the state to invest in the Collaborative Care Model.

Total Drug Fatalities in Utah

Total drug-related fatalities in Utah increased in 2020-2021; however, preliminary data from 2022 show a slight decrease. The main drivers of the 2020-2021 increase were fentanyl and methamphetamine, which was the most common drug involved in fatal overdoses. Deaths from prescription opioids and heroin slightly decreased.[26]

Utah's methamphetamine-involved deaths increased nearly 2.5 times from 5.6 per 100,000 adult population in 2015 to 12.2 in 2021.[27]

Figure 5: Total Drug-Related Fatalities in Utah and the U.S., 2011-2020



Note: Total drug-related fatalities include those coded as unintentional, suicide, homicide, or undetermined intent.
Source: Utah Department of Health and Human Services, Indicator-Based Information System for Public Health

- Allow providers to bill for physical health, mental health, and SUD services in same day (possibly consider alternative payment models).
- Ensure that individuals with alcohol, opioid, and other substance use disorders have access to primary-care based SBIRT for SUDs, Medication Assisted Treatment, and Office-Based Opioid Treatment.

Now's the Time: Utah's Aging Population

Utah's average age remains the youngest, but the state has one of the fastest growing per capita populations of adults age 65+ in the country. Projections indicate that Utah's older population (ages 65+) will more than triple over the next several decades—from 376,000 people in 2020 to 1.2 million in 2060—which is shifting demand for behavioral health services to older adults.[28]

While demand for services is increasing, interviewees noted that Utah only has a small number of geriatric psychiatrists in the state (two that work outside of the VA), and that rural-area access is especially limited. There are few geriatric-trained mid-level practitioners like advance practice registered nurses (APRNs), physician assistants (PAs), social workers, and neuropsychologists.

Expanding the number of behavioral health professionals trained in geriatric care is necessary, but slow. Parallel clinical approaches should include risk prevention and early disease identification to help prevent, delay, and treat the onset of psychiatric and/or dementia symptoms, centralized resource awareness and education, and increased clinical-level coordination between the patient's existing primary care, care manager, and behavioral health providers. There is also a need for better and more complete communication for hospital discharges and transition of patients to the home or facilities (and vice versa). This requires more extensive behavioral health training in the primary care setting and targeted consultations with behavioral health specialty providers. One participant noted that "primary care docs ***should*** be able to diagnose and treat cognitive decline."

It is also important to note that the Utah Commission on Aging (UCOA) is in the process of developing a Master Plan on Aging that will more comprehensively identify and address the behavioral health needs of older adults among other issues such as preventive care, homelessness, disabilities, family caregiving, etc. It is expected this plan will be complete in November 2023.

NEXT

Actions

- Where appropriate, promote training on brief physical health interventions and therapies for behavioral health providers working in integrated settings.
- Continue to support, expand, and sustain training and technical assistance to pediatricians, medical providers, and other licensed clinicians across the state working to implement integrated or team-based approaches.
- Foster systemic connections between community behavioral health providers and school-based mental health professionals (e.g., encourage schools, local authorities, and other community providers to align care needs and ensure referral pathways or other ways to access a comprehensive continuum of behavioral health services and supports).
- Improve the availability of high-quality behavioral health services for populations at the beginning and end of the lifespan (infant and early childhood, youth ages 6-12, and the geriatric population), including improved primary care based behavioral health care provided by pediatricians and physicians treating the aging population.

FUTURE

Key Decisions

- Are there effective integrated care models utilized in behavioral health outpatient specialty services that create direct linkages back to primary care? How to expand, support, or develop these models?
- How to expand integrated care models across the continuum of behavioral health services and supports so it is not limited to primary care?

Actions

- Develop enhanced, regionally based referral networks to support pediatricians and primary care providers with screening and early identification, and create connections to specialty behavioral health providers, for patients who need higher-level care due to complex or chronic behavioral health conditions.
- Incentivize system structures and payments for evidence-based integrated care approaches that address the physical and behavioral health of individuals and families.[29]
- Evaluate gaps in effective community-based behavioral health programming (across populations, communities, and geographies) and determine what research-based programs, digital tools, and other services could be expanded, supported, developed, and coordinated to promote behavioral health, wellness, and the management of mild-to-moderate behavioral health concerns.

Evaluate ways to reduce barriers in the delivery of services across and within public physical and behavioral health systems.

The Master Plan supports evaluating ways to reduce barriers in the delivery of services across and within the state's public physical and behavioral health systems.[30] This could include evaluating what changes to make to best reflect the growth and development of behavioral health needs and services over time. Proposed policy and program changes should take into account safety net behavioral health funding for services provided to the SMI and uninsured populations as well as the critical wraparound services provided by the counties.

NOW

Key Decisions

- How to increase access to integrated care across Medicaid and other public and private markets to make it easier for individuals and families to access care earlier in the continuum of behavioral health services and supports? What incentives and funding flows are needed?
- What are the roles and responsibilities of state and county government with respect to delivering behavioral health services, providing access to care, reducing suicide and overdose deaths, etc. as currently provided and as outlined in Utah Code?[31]
- How to streamline Medicaid benefits and plan options?
- How to streamline the roles of state regulatory agencies to reduce unnecessary administrative complexities for providers?

- How to improve continuity of care in Medicaid? (e.g., establish continuous eligibility for adults in Medicaid to prevent people from switching programs more than necessary)
- Should Medicaid beneficiaries have a choice of providers and services? Evaluate network adequacy or freedom of choice waiver 1915(b)?
- How to define network adequacy? What are appropriate wait times, etc.? How does network adequacy differ in Utah's rural and frontier areas?
- How to simplify plans options within Medicaid to reduce disruption when Medicaid members have eligibility changes?

Actions

- Convene county officials, managed care organizations, and providers to determine appropriate integrated delivery models for each area. Models could include collaborative care, integrated accountable care organizations, or integrated behavioral health care programs.[32]
- Harmonize performance metrics and reporting requirements across Medicaid and the Office of Substance Use and Mental Health (SUMH).
- Simplify and streamline behavioral health related billing, coding, reporting, and other administrative requirements across Medicaid's ACOs.

Encourage better alignment of integrated behavioral health across public and private payers and systems.

While it is important to address the integration of physical and behavioral health within Utah's public health systems, only a fraction of Utah's population qualify for public services. The majority of Utahns access behavioral health services in private systems and are covered by private health insurance plans.

The Master Plan supports strategies to better align integrated behavioral health across public and private payers and systems, including easing administrative complexities for private providers. Such strategies can help improve access to necessary and appropriate behavioral health care for all Utahns, increase parity of mental health and SUD services, and address reimbursement concerns.

NEXT

Key Decisions

- How to streamline current behavioral health regulations and administrative requirements across public and private payers and systems to reduce unnecessary administrative complexity for behavioral health providers and consumers?
- How to address the movement of behavioral health providers from the public/private market to the self-pay or cash-only market (e.g., address administrative burdens, incentivize providers to participate on insurance panels, etc.)

Actions

- Improve awareness and use of available behavioral health related codes across public and private payers.
- Simplify and streamline state licensing, certification, and credentialing.
- Begin to engage with private payers, self-funded employers, self-pay providers, and other direct-to-consumer market entrants (e.g., Employee Assistance Programs (EAP), online mental health/counseling platforms, etc.) to create a shared vision for a coordinated system.

An Unknown: The Impact of a Growing Direct-to-Consumer Market

The already growing market for direct-to-consumer and digital mental health services expanded during the COVID-19 pandemic.[33] These online services and digital tools help create access and can be effective options for individuals with mild-to-moderate mental health needs.

There are some possible concerns to watch for with this growing market, however, which include the efficacy of the services and tools, data privacy and security, connection to a full continuum of local mental health services and supports if higher-acuity services or supports are needed, and ensuring certain populations are not left out as the market transitions to these new models of care (e.g., populations that cannot afford to pay cash for services, populations with low-digital literacy or limited access to broadband services, etc.).

Direct-to-Consumer Market

FUTURE

Key Decisions

- What are the roles and responsibilities of public and private behavioral health providers, including self-pay providers?
- What type of structure needs to be in place to help align and enforce parity across these different markets?
- How to create equitable access to behavioral health benefits for an increasing number of individuals with HDHPs and employer-based self-funded plans?
- How to improve access and choice across private payers and systems?
- How to develop capitated payment models for different populations that include cost savings in and beyond behavioral health to reflect the entire medical cost?
- How to attribute costs to the appropriate payer (both public and private) and avoid cost shifting from the private to the public market?
- Are there essential behavioral health services that private health insurance plans should be responsible for covering?
- How to address reimbursement disparities between behavioral and physical health?

Actions

- Consider ways to align private health insurance benefits with Medicaid.
- Encourage private payers to simplify and streamline administrative functions and requirements such as credentialing, billing, coding, reporting, etc.

High-Deductible Health Plans (HDHPs) and Health Savings Accounts (HSA)

Employer and consumer education around how to effectively use HDHPs will be important as the percentage of Utah's health insurance market covered by HDHPs grows. HSA-qualified HDHPs accounted for 40.1% of Utah's comprehensive health insurance market in 2021, compared with only 3.0% in 2007.34 These plans have lower monthly premiums, but the higher deductibles require individuals and families to pay more in out-of-pocket costs before their insurance plan begins to cover expenses. Today, HSA-qualified high-deductible family health plans have a minimum deductible of $3,000 with a maximum of $15,000 in out-of-pocket expenses.[35] This means that consumers enrolled in these plans are responsible for paying $3,000 of their covered health care expenses (or more if the deductible is higher) before the insurance company begins to pay a portion of the costs.

While HDHPs may save individuals and families money in the short run through lower monthly premiums, they can deter some individuals from seeking appropriate medical care because of the higher, upfront out-of-pocket costs.[36] Data from the National Health Interview Survey show that about 1 in 10 adults report delaying or going without medical care due to costs. This portion increases to one in four among uninsured adults.[37]

4 Improve patient navigation and continue to build out Utah's behavioral health crisis and stabilization systems.

The Master Plan supports:

4a. Promoting effective behavioral health service navigation tools.

4b. Expanding and sustaining Utah's crisis and stabilization services.

Improving crisis services is a current focus for the state, but more work can be done to continue to expand these initiatives to ensure all Utahns have access to effective and sustainable crisis and stabilization services (including referrals to high-quality, community-based outpatient specialty services). Crisis and stabilization services help patients more fully engage in treatment and move to self-sustaining recovery. These services help people enter treatment earlier on, and at a lower cost, reducing overall costs in the health care system.

Promote effective behavioral health service navigation tools.

While the perception is that stigma is lessening, the need to improve public awareness of behavioral health is ongoing. This includes increasing behavioral health literacy and providing education that is outcomes-focused and consumer-informed. A key component of this education is providing behavioral health navigation tools that help consumers understand how to access high-quality behavioral health services and help providers manage and coordinate care.

The Master Plan supports strategies that promote effective behavioral health navigation tools that help reduce time between symptom development, identification of need, and engagement in appropriate care in the least restrictive setting. While existing tools could be better promoted and coordinated,[38] it is important to note that the development of future tools should occur after the implementation of major reforms recommended by the Master Plan to account for possible structural changes to Utah's behavioral health system.

NOW

Key Decisions

- Examine ways to better coordinate or align existing navigation services and tools across sectors and geographies.
- How best to help employers understand behavioral health coverage and purchase the best plan and services for their employees?

Actions

- Continue to promote existing navigation services such as the Behavioral Health Navigation Line (833-442-2211), healthyminds.utah.gov, sumh.utah.gov, etc.
- Continue to create a central landing page for parenting resources related to prevention services and other evidence-based programming.
- Provide more education and awareness of the comprehensive continuum of behavioral health services and supports with a priority focus on (1) prevention and early intervention (to address mild-to-moderate behavioral health needs); and (2) crisis and diversion services as receiving centers and mobile crisis outreach teams (MCOTs) are expanded across the state.
- Provide more effective outreach and education using culturally and linguistically appropriate materials that meet the needs of individuals with low literacy, low health literacy, and limited-English proficiency.

NEXT

Actions

- Encourage employees with HDHPs to contribute more to HSA/flexible spending accounts and provide more consumer education on if preventive services are available at no cost (e.g., depression screening, some anxiety screening, and some services and items related to diagnosed depression),[39] access points, and costs related to behavioral health services.
- Implement, evaluate, and possibly expand the statewide bed registry to show bed availability at inpatient, residential, partial hospitalization, med-detox, social detox, receiving/access centers, crisis respite homes,[40] intensive outpatient, and other high-acuity levels of care.
- Create consolidated, effective, holistic, transparent, and outcomes-based patient navigation services that help consumers across the population lifespan (infant to geriatric), and in different areas across the state, access a full continuum of behavioral health services and supports (i.e., the right services at the right time and the right place).

FUTURE

Actions

- Develop and leverage digital tools at each level of Utah's continuum of behavioral health services and supports to help link that level back to a full continuum of care.

Expand and sustain Utah's crisis and stabilization services.

Crisis and stabilization services (like Utah's community-based behavioral health receiving centers, Intermountain Health's access centers, and MCOTs) help prevent behavioral health issues from escalating. Utah's Behavioral Health Crisis Response Commission is in the process of developing a comprehensive coordinated crisis system designed for anyone, anytime, and anywhere. Key goals include better care, hospital diversion, and law enforcement/jail diversion. The Master Plan supports strategies that align with the Commission's recommendations as well as additional strategies that ensure crisis services are expanded and enhanced to reach all Utahns.

NOW

Actions

- Ensure crisis/diversion services across the state are sufficient to meet the needs of the justice and correction systems as they develop effective, coordinated diversion strategies.
- Ensure current crisis services are appropriately funded. Local authorities have limited resources to provide crisis outreach, 24-hour crisis support, and subacute care within their current allocations. To ensure individuals in crisis receive appropriate and quality care, additional funding is needed for Utah's crisis response infrastructure.
- Expand access to the crisis call center (with linkages to care), MCOTs, receiving centers and 23-hour observation, and subacute hospitalization statewide. Address challenges with expanding rural-area crisis/diversion services.
- Expand private health insurance reimbursement of crisis services (including receiving centers, MCOTs, etc.), including promoting the use of bundled payments that reflect regional needs.

NEXT

Actions

- Determine ways to improve coordination between publicly and privately operated crisis/diversion services to maximize availability and access and improve navigation by consumers, providers, law enforcement, and other sectors and stakeholders across the state.
- Broaden the behavioral health crisis system to integrate SUD intake and treatment more fully.
- Ensure crisis services are integrated into a full continuum of behavioral health services and supports across public and private systems and sectors, ensuring access to a comprehensive system.
- Expand private health insurance reimbursement of evidence-based supported employment/education, individual and family respite services and supports, and other levels of care (psychosocial rehab, psycho-education, etc.).

5 Improve the availability of services and supports for individuals with complex behavioral health needs.

A critical gap in Utah's continuum of behavioral health services and supports is the availability of appropriate and effective services for Utahns with complex behavioral health needs. While Utah has some services, access is not consistent across different communities, different populations, and different complex behavioral health conditions.

Examples of such services and supports include withdrawal management and detox services, residential, partial hospitalization and other intensive outpatient services, recovery services and supports, and subacute care. For purposes of this report, subacute care includes a variety of long-term services and supports provided in a non-acute hospital or other long-term care setting for people recovering from an acute behavioral health condition. The lack of these "step up" and "step down" services for Utahns moving away from institutional settings (hospitals, prisons, etc.) contributes to capacity issues experienced by inpatient care facilities.

The Master Plan supports strategies to ensure these services are coordinated, expanded, enhanced, and community-based to create a functional and sustainable system to meet the individual needs of all Utahns with complex behavioral health issues.

NOW

Key Decisions

- How to create and promote reimbursement structures in public and private markets that reflect risk, costs, regional differences, and the complexity of care?
- What type of payment models or levels of reimbursement are necessary to sustain subacute facilities and community-based programs for individuals with complex needs?

- Should public and private markets establish differentiated rates based on risk and outcomes that are appropriate for the population served?
- How to create and determine levels of care? (e.g., clearly articulated "stepped care" approaches; consider using American Society of Addiction Medicine's (ASAM) criteria)
- What type of oversight models are effective in managing providers' concerns with private health insurance plans related to subacute, acute, inpatient, and residential behavioral health care coverage and reimbursement?
- How to address the mental health "institutions for mental disease" IMD gap? (e.g., modify the Medicaid waiver)
- What are the current and future needs for civil and forensic beds at the Utah State Hospital?

Actions

- Implement autism-spectrum disorder (ASD) services for all populations enrolled in Medicaid as part of the Medicaid state plan (per S.B. 204, 2023).
- Evaluate gaps in recovery resources and others supportive services (across populations, communities, and geographies) and determine what research-based programs, tools, and services could be expanded, supported, coordinated, or developed to fill the gaps.

Mental Health and ID/DD Landscape Analysis: Utah's Institute for Disability Research, Policy & Practice

Utah's Institute for Disability Research, Policy & Practice at Utah State University is currently engaged in a landscape analysis to evaluate capacity and needs within current systems of care for people with mental health and ID/DD, with a specific focus on the needs of unserved/underserved and culturally diverse populations in Utah.

The purpose of the landscape analysis is to: (1) evaluate the efficacy and impact of the current disability service system with regards to supporting the mental health needs of individuals with ID/DD; (2) identify current gaps in mental health supports for individuals with ID/DD; and (3) identify training needs to help build the capacity of service providers to support the mental health of individuals with ID/DD. The results of the landscape analysis should be complete in summer 2023.

- Partner with people in recovery and their family members to foster health and resilience and improve awareness of, connection to, and coordination with community-based support groups across the state (e.g., National Alliance on Mental Illness (NAMI), Utah Support Advocates for Recovery Awareness (USARA), faith-based organizations, etc.).

NEXT

Key Decisions

- How to coordinate with the Department of Workforce Services (DWS) and Utah Homelessness Council to ensure integrated, appropriate, and affordable housing options exist statewide to prevent homelessness and assist near-homeless persons with behavioral health needs?
- How to improve funding and coordination with the Division of Services for People with Disabilities (DSPD) to address gaps in services for persons with ID/DD, including acute, intermediate, and transitional programs for both youth and adults with co-occurring behavioral health needs? Work with Utah's Institute for Disability Research, Policy & Practice at Utah State University to assess gaps, evaluate why gaps exist, identify best practices, and develop solutions.
- How best to serve the high-need juvenile justice population?
- Should the state establish a Utah State Hospital operated long-term care facility?
- Consider the development of regionally appropriate medical home models for different populations (e.g., create behavioral health homes for SUD).
- How to create sustainable funding for addiction recovery services, including improved socialization and standardization of these services?

Actions

- Expand intensive outpatient options by adjusting Medicaid and private health insurance reimbursement models to support sustainability.
- Create sustainable funding/reimbursement models that promote the development and expansion of subacute programs that that match the right level of care to right level of need and are coordinated with a comprehensive behavioral health continuum of care, ensuring an

integrated system (consider intermediate acuity care facilities, community-based models, crisis respite homes, individual, family, and crisis respite services, etc.).

- Promote bundled payments or global fees for episodes of care to improve reimbursement for individual and family respite services and supports, club houses, recovery supports, and other specialized services such as Coordinated Specialty Care (CSC) for psychosis prevention and early intervention.
- Develop or expand programs that support individuals with co-occurring and complex needs.
- Expand integrated supportive housing, assisted living, and community and residential support programs and models across the state.
- Expand the availability of long-term care beds at the Utah State Hospital and other inpatient/residential facilities as needed.
- Create sustainable funding/reimbursement models for acute care services and residential care.

FUTURE

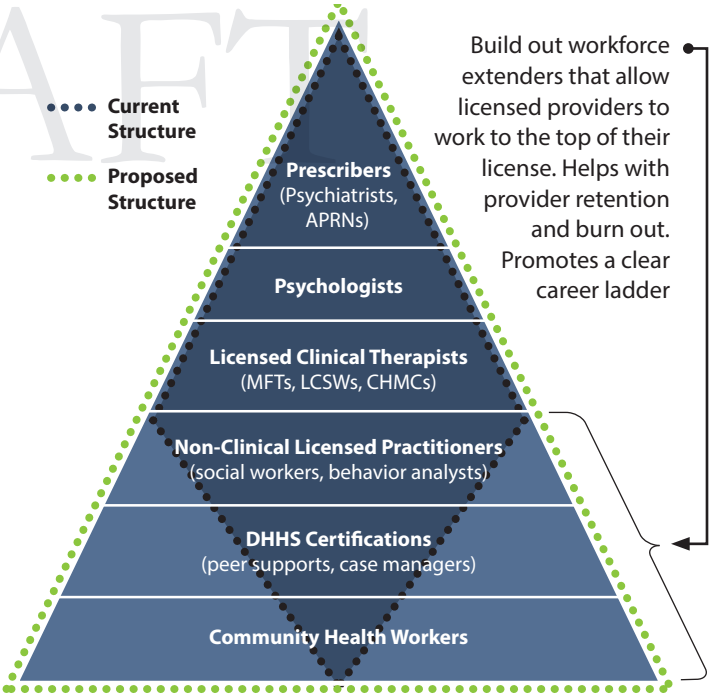
Key Decisions

- Expand access to resources that support the four major dimensions of recovery: (1) health; (2) home; (3) purpose; and (4) community.[41] Examples include but are not limited to individual and family respite services and supports, peer supports, CHWs, housing, home and community-based services, supported employment/education, transportation, childcare, access to healthy food, and other social supports).

6 Expand and support Utah's behavioral health workforce.

Utah's ongoing—and growing—behavioral health workforce shortages are a challenge that is disrupting care across the state and the continuum of behavioral health services and supports. The Master Plan supports strategies to (1) attract, retain, and develop a diverse behavioral health workforce, (culturally, linguistically, and from historically marginalized populations); (2) grow and develop a sustainable behavioral workforce across provider types (licensed, certified, and professional/para-professional); and (3) create supports and incentives for clinicians to work to the top of their license. Many of these strategies are being developed and promoted by the Utah Substance Use Advisory and Mental Health Advisory Council (USAAV+),[42] Utah's Health Workforce Advisory Council,[43] and Utah's Area Health Education Centers (AHEC).[44]

Figure 6: Building out Workforce Extenders to Support Utah's Behavioral Health Workforce



Note: Data from OPLR's review of mental and behavioral health licenses in Utah show Utah's behavioral health workforce is currently missing the base levels, resulting in a diamond shape. OPLR suggests that building out the sections that require less training (i.e., certified or credentialed non-licensed professionals) is an effective way to address the shortage.
Source: Kem C. Gardner Policy Institute. Based on OPLR's review of mental and behavioral health licenses in Utah.

The Master Plan also includes a specific focus on increasing the use of certified or credentialed non-licensed professionals to extend the current workforce (e.g., peer supports, CHWs, case managers, etc.). Effective use of certified or credentialed non-licensed professionals as part of an integrated care team can (1) support licensed providers and help them work more effectively to the top of their license (which helps with provider retention and burn out); (2) promote a clear career ladder within the behavioral health field; (3) create a workforce that is more inclusive and mirrors individuals served (which helps reduce inequities, disparities, and stigma), and (4) assist with care transitions and patient navigation.

NOW

Key Decisions

- How to streamline training and certification of the behavioral health workforce?

Actions

- Maintain advancements made to telehealth during the COVID-19 Public Health Emergency (PHE), including ensuring meaningful and equitable reimbursement.
- Establish Medicaid reimbursement for CHWs (develop state plan language that is broad enough to encompass behavioral health issues and referral supports).
- Provide training to providers, schools, and other sectors and settings on how best to deploy non-licensed professionals as care team members to improve adoption of effective strategies and support coordination with primary care providers.
- Improve the certification process and standardize training of non-licensed care team members to help reduce quality differences.
- Continue to promote and support the training of behavioral health providers on working with and providing services to culturally diverse populations.
- Support Utah's behavioral health workforce adopt, expand, or develop models that address stigma (e.g., peer supports, encourage help-seeking behaviors, etc.)

NEXT

Key Decisions

- What levels of reimbursement are needed to expand peer supports, case managers, CHWs, and other non-licensed care team members?
- How to ensure case management is available to diverse populations to address the social determinants of health (SDOH) before issues become a crisis?

Actions

- Promote use of bundled payments to improve reimbursement for peer supports, CHWs, case management, etc. and reflect regional needs.
- Expand private health insurance reimbursement of research-supported recovery-based models that rely on non-licensed professionals, such as peer supports, case management, etc.

FUTURE

Key Decisions

- How to create incentives for enhancing the workforce pipeline, including increasing diversity (culturally, linguistically, and across provider types) across the state?
- How to address structural barriers that may prevent persons from participating in Utah's behavioral health workforce? (e.g., licensure exams, background checks, etc.)
- How best to partner with people in recovery and create pathways for them to work in behavioral health fields?
- What methods are most successful in educating high school students on behavioral health careers to create a more robust future workforce? (e.g., connect with AHEC)

Actions

- Evaluate pathways for upward mobility by developing career ladders through bridge and/or tuition support programs to allow non-licensed professionals to train and obtain certification or licensure to advance into the clinical system.
- Encourage health plans to demonstrate provider networks that are geographically accessible, offer timely care during convenient hours, and are language accessible and culturally literate (could include leveraging telehealth and effective digital tools as well as contracting with a workforce that is grounded in peer recovery, peer support, case management, and community based).
- Promote statewide public-private partnership service delivery models that offer incentives for providers and public payers to reach underserved areas and populations in Utah.

Mechanism for Maintaining this Work

When developing the Master Plan, it became apparent to the Utah Behavioral Health Coalition that a mechanism is needed to achieve better system-level coordination and maintain the work of the Master Plan over time.

The group concluded that a governing authority is key to this process. While the specifics of the governing authority are still being determined, the Coalition envisions that the governing authority will:

- Recognize behavioral health is essential to a person's health.
- Oversee future efforts to ensure Utah's behavioral health systems are comprehensive, aligned, effective, and efficient.
- Be a public/private partnership that helps develop methods/models for implementing and coherently communicating cross-sector strategies.
- Be accountable to clear, measurable outcomes.

Some questions that need to determined regarding the governing authority include:

- What are the roles/responsibilities of the governing authority?
- What measurable outcomes will it be responsible for achieving?
- What metrics will be used to measure success for each of the strategic priorities?
- Should it create a scorecard or dashboard for monitoring progress?
- How will it consolidate or align with existing behavioral health commissions/councils (e.g., the Utah Behavioral Health Crisis Response Commission, the Education and Mental Health Coordinating Council, USAAV+, etc.)
- How does it oversee, promote, and coordinate the development of recommendations in the Master Plan?
- What metrics will it use to assess gaps in access? (e.g., identify key underserved, high-risk populations and monitor them to ensure system-level strategies do not further exacerbate inequities)
- How to engage Utah's employers as partners in the development and implementation of the Master Plan?
- How to ensure a rural area focus?

Overview of the Environmental Scan Process

Building On Previous Assessments

The environmental scan builds on and expands previous research and system assessments conducted by the Gardner Institute, including an overview of Utah's Mental Health System (2019),[45] Utah's Early Childhood Mental Health System (2020),[46] and Medication-Assisted Treatment for Opioid Use Disorder in Utah (2020).[47] More information about Utah's behavioral health system is available in these reports.

The environmental scan also builds on two reports:

1. In February 2020, UHA released A Roadmap for Improving Utah's Behavioral Health System.[48] The Roadmap was developed in collaboration with UHA's behavioral health committee and mental health workgroup, comprising members of the mental health community. The purpose of the roadmap was to provide a guide that policy makers, UHA, and other stakeholders can use to support legislation, policy decisions, and program development to help ensure every citizen in the state of Utah has access to appropriate behavioral health services and supports. The Roadmap includes a set of tiered recommendations that primarily focus on mental health and represent initial steps to system improvement.

   A 2021 End-of-Year Update[49] to the Roadmap, released in December 2021, provides an update on the recommendations included in the 2020 Roadmap, details current and recent initiatives, and highlights some remaining gaps in the system based on the initial set of recommendations.

   Recognizing the importance of addressing both mental health and substance use disorders, UHA acknowledged that a broader assessment was needed that considers the many sectors connected to or impacted by Utah's behavioral health system. These include public and private behavioral health systems and providers, Medicaid and private health insurance plans (both commercial and self-funded), housing and homeless services, child welfare, services for persons with disabilities, schools, the court systems, criminal justice, law enforcement, etc.

   It is also noteworthy that the COVID-19 pandemic immediately followed the release of the Roadmap, increasing behavioral health needs nationwide and further impacting the systems in place to serve Utahns. These more recent environmental factors were considered and incorporated within this report.

2. In March 2022, The Children's Center Utah released A Pathway for Improving Early Childhood Mental Health in Utah.[50] Using the "Early Childhood Mental Health in Utah" report to better understand the state's early childhood mental health needs, The Children's Center Utah assembled the Utah Early Childhood Mental Health Working Group in 2021 to develop strategies and tactics to strengthen and improve early childhood mental health in Utah. The working group consists of stakeholders from a variety of early childhood-related professions and backgrounds.

   The group is currently working on efforts to: (1) create a baseline estimate of need for early childhood mental health services; (2) increase integration of physical and behavioral health for children by examining financing policies for addressing early childhood mental health needs before they escalate to the point of functional impairment; and (3) increase early childhood mental health awareness.

To help ensure the Master Plan aligns with other work, the Gardner Institute and LP/HMA also reviewed other available reports, information, and data related to Utah's behavioral health system as well as tracked current initiatives such as the One Utah Roadmap, Utah's Department of Health and Human Services merger, and Utah's Behavioral Health Delivery Workgroup, among others.

While this review was comprehensive, it is possible that not all initiatives were captured given the tremendous amount of public and private-sector work currently occurring within Utah's broad behavioral health system.

Capturing Recent Changes to Utah's Behavioral Health System

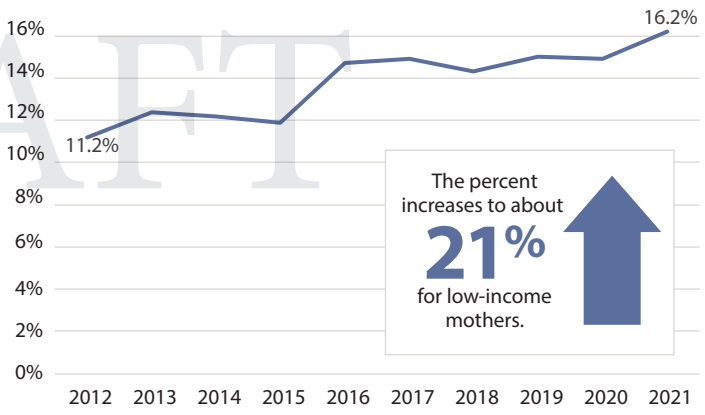
While the structure of Utah's behavioral health system is largely the same as what is outlined in the 2019 Utah's Mental Health System report, it is important to note some recent changes that have, are, or will influence Utah's behavioral health system. These include, but are not limited to:

- DHHS assuming responsibility for health care in Utah's prison system beginning July 1, 2023.
- Opioid Settlement Fund payments (started October 31, 2022).
- Merger of the Utah Department of Health and Department of Human Services (July 1, 2022).
- Creation of the Utah Homelessness Council and state Homeless Coordinator (2021).
- Creation of the Education and Mental Health Coordinating Council (2021).
- Expansion of Utah's crisis system, including receiving centers and MCOTs (all counties in the state currently have access to active MCOTs) (2020-2023).
- Expansion of the Behavioral Health Crisis Response Commission and establishment of 988 as a nationwide 3-digit number for mental health crisis and suicide prevention services (2021-2022).
- Full Medicaid expansion (January 2020), which extended Medicaid coverage to Utah adults with annual income up to 138% of the federal poverty level (FPL). The federal government covers 90% of the costs for these services, with the state covering the remaining 10%.
- Utah Medicaid Integrated Care (UMIC) program that manages physical and behavioral benefits for Utah Medicaid's adult expansion population through integrated managed care plans in five counties: Davis, Salt Lake, Utah, Washington, and Weber (January 2020).

2023 legislation related to behavioral health also includes, but is not limited to:

- S.B. 86: Designed to reduce fentanyl overdose deaths by decriminalizing the use of fentanyl test strips.
- S.B. 133: Provides 12-month postpartum coverage for low-income new mothers. Expanded postpartum coverage can help address issues like postpartum depression and anxiety (Figure 7).
- H.B. 66: Provides over $5 million in new funding to add new receiving centers and MCOTs.
- H.B. 166: Allows for the provision of some remote mental health therapy and substance use disorder counseling.
- H.B. 248: Provides an additional $1 million in funding for adults with mental health challenges.

Figure 7: Share of New Mothers Reporting Postpartum Depression Symptoms, 2012-2021



Note: The data represent self-reported postpartum depression symptoms and not clinical diagnoses of postpartum depression.
Source: The Utah Department of Health and Human Services Pregnancy Risk Assessment Monitoring System (PRAMS)

Environmental Scan: Detailed Findings

METHODOLOGY

To understand the current state of behavioral health care in Utah, highlight gaps in services, identify barriers to providing and accessing care, and solicit considerations for improving Utah's behavioral health system, the Gardner Institute and LP/HMA conducted 30 formal discussion groups and in-depth interviews from June 2022 to January 2023 (see Textbox on p. 5 for more detail). The Gardner Institute and LP/HMA also continue to engage in additional informal interviews with groups and individuals that are interested in more targeted discussions about current initiatives or concerns.

The goal of the discussion groups and interviews is to gather information and feedback for a comprehensive review of Utah's behavioral health system. An overview of system-level issues and detailed findings from the discussion groups and interviews are presented in the subsequent sections. The information is organized along the same sections that are presented in the continuum of behavioral health services and supports developed for the initial Roadmap (Figure 1). Each section includes information mentioned during the discussion groups and interviews related to:

- Gaps, challenges, and needs associated with that section of the continuum.
- Bright spots (system highlights or successes mentioned during the discussion groups). As noted above, there are many positives about Utah's behavioral health system. While not every bright spot is captured here, it is important to acknowledge what is working well to help avoid unintentional consequences when developing reforms.
- Suggested ideas for next steps. Not all recommendations align with or address the key issues highlighted above and may not align with the recommendations developed for the Master Plan.

It is also important to note that the discussion groups and interviews provided information on the perceptions of behavioral health care in Utah. Qualitative research aims to gain a deeper understanding of opinions and attitudes on an issue. As such, responses are more nuanced, may not be generalizable, and are somewhat determined by the flow of conversations in individual groups.

PROMOTION AND PREVENTION

Behavioral health promotion, prevention, and early intervention is important for addressing Utah's growing behavioral health needs, particularly among Utah's infants, young children, and youth. Improving the general population's understanding of behavioral health and preventing or delaying the escalation of worsening behavioral health issues, can improve access to care—as well as place downward pressure on health system costs—by reducing the need for more acute behavioral health services.

50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24.[51]

Gaps, Challenges, and Needs:

- *Stigma.* While mental health stigma has lessened over the last few years, participants noted that stigma still exists, particularly for some groups including residents in rural areas, active military and veterans, homeless populations, persons in the criminal justice system, and some families accessing child and family services (due to fear and distrust of the child welfare system). Discussion groups also noted that stigma is still associated with SUD issues, including from medical providers due to a lack of training. This can make it difficult to provide care to that population in an integrated setting.

"People Need Hope"

To combat stigma, discussion groups noted that messaging around mental health and SUDs needs to focus more on behavioral health, wellness, and disease being a normal part of a person's health, and that behavioral health conditions can be treated. "Recovery is possible."

- *Insufficient funding.* It was noted that promotion, prevention, and community education programs (see section below) in general need more funding, resources, and support to be sustainable and generate long-term impacts. This includes:
  - Federal and state funding (e.g., more federal block grant funding directed to mental health and SUD prevention).
  - Adequate reimbursement for mental health and SUD prevention services provided in a medical or behavioral health treatment setting (e.g., screenings).
  - Community-directed discretionary funding for promotion and prevention services. It was noted that many community-based prevention and education programs focus on physical health and nutrition. More support is needed for behavioral health focused programs.
- *A lack of system coordination.* A lack of system coordination leads to the development of "siloed" prevention systems. For example, it was noted that there are several coalitions addressing similar risk and prevention factors. While each of these coalitions was developed with a specific purpose, better alignment could help create more efficiencies within the system. Other issues include:
  - Many health systems are developing or utilizing their own promotion, prevention, or early identification programs, tools, and services, which may not be aligned with or connected to the broader system, creating challenges with transition support and patient navigation.
  - Some programs do not have the resources or financial support to expand beyond a specific population or region, adding to existing system silos and the need to duplicate services.
  - There is not a single point of contact or resource directory in the prevention space, which makes it difficult to know how or where to access prevention, parenting, educational, and early intervention programs.
  - As a specific example, it was suggested that the court system could be better connected to the state's existing prevention efforts to better address the needs of its population before they commit serious crimes for which they may be incarcerated.

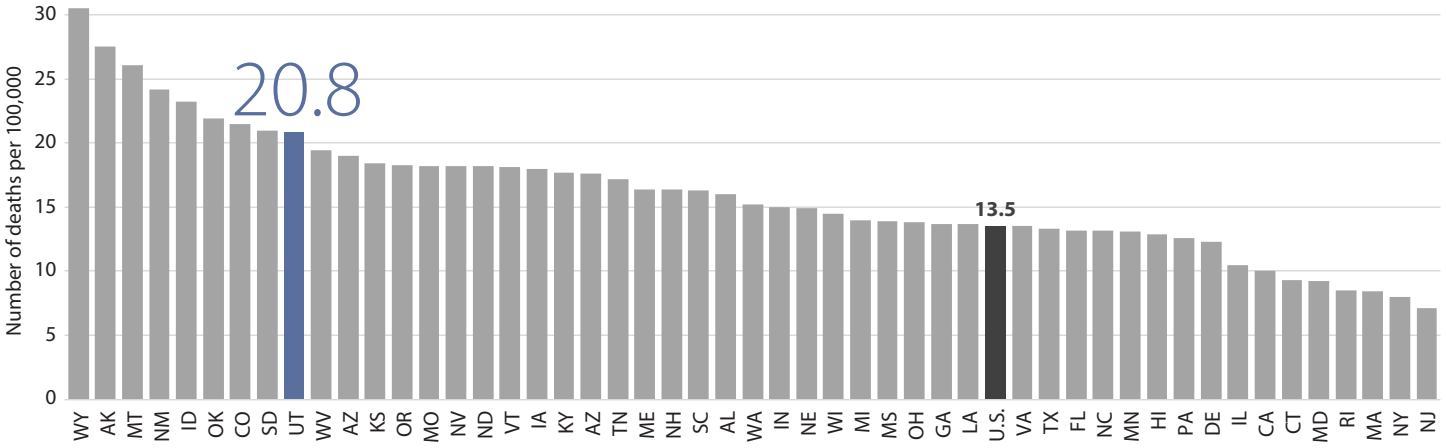
Bright Spots:

- *Utah has an existing base to build on.* It was noted that Utah has a mature, evidence-based, well-organized prevention system that can be built on and expanded.
- *Increasing focus on prevention efforts by both the Utah Legislature and state agencies.* Examples noted during the discussion groups include:
  - Prevention being a primary focus for the Utah's opioid settlement funds.[52]
  - DHHS supporting Blueprints for Healthy Youth Development Programs,[53] a registry of evidence-based positive youth development programs designed to encourage the health and well-being of children and teens.
  - The Utah Legislature appropriating significant funding to suicide prevention (including the Governor's Suicide Prevention Fund) and suicide prevention training.
- *Live On Suicide Prevention Campaign.* "Live On"[54] is a public-privately funded suicide prevention campaign that receives financial support from the Legislature, Governor's Office, SUMH, Intermountain Health, and others. It is supported by the Utah Suicide Prevention Coalition, a partnership of community members, suicide providers, researchers, and others dedicated to saving lives and advancing suicide prevention efforts in Utah.[55] Its goal is to advance efforts to educate the public about the warning signs of suicide, how to listen and intervene, and to save lives by linking individuals to appropriate services.

Utah's Suicide Rate is High, but Has Been Declining in Recent Years

Utah's adjusted suicide rate in 2021 was 20.0.[56] Utah's suicide rate was ninth highest in the country in 2020 (2021 data for all states is not yet available). Utah's rate has been declining in recent years, from 22.7 deaths per 100,000 total population in 2017 to 20.8 in 2020. However, suicide rates among Utah males are close to four times higher than the rate among Utah females (31.8 vs. 8.3 age-adjusted rate per 100,000 population, 2021).[57] Rates are also highest among Utah's American Indian/Native Alaskan populations (21.2, 2019-2021 combined data).[58]

Figure 8: Suicide Rate by State, 2020



Note: Rates are adjusted for differences in age-distribution and population size.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

- *HMHI anti-stigma working groups.* HMHI hosts monthly Utah Mental Health Anti-Stigma community meetings open to any Utah individual or organization working to eliminate the stigma around mental health and SUDs. This stakeholder community has formed 10 working groups focused on specific stigma contexts, made up of 125 diverse individuals representing many populations and sectors from across the state (e.g., health care, business, nonprofit, schools, and government leaders). The goals of the Utah Stop Stigma Together Initiative are to create a social movement that changes public perception about stigma related to mental health and SUDs, build a leadership community in Utah that works collaboratively to eliminate stigma, and to address population specific needs.
- *Governor Cox's social media initiative.* In October 2022, Governor Cox announced the creation of the Office of Families, under the Division of Family Health, which will focus on addressing social media's negative impact on teens. The Governor will be working with legislators to develop policies that would require parental permission for the creation of minors' social media accounts.[59] In March 2023, the Surgeon General issued an advisory about the effects of social media use on youth mental health.[60] The advisory cites research that shows that "adolescents who spend more than three hours per day on social media face double the risk of experiencing poor mental health outcomes, such as symptoms of depression and anxiety." The advisory also notes that most teenagers spend an average of 3.5 hours per day on social media.

Suggested Ideas for Next Steps:

- Maintain support for the Utah Student Health and Risk Prevention (SHARP) survey and other data collection efforts that identify mental health and SUD needs (e.g., rates and regional variation).
- Develop a common certification or a minimum set of training criteria for prevention specialists and others providing prevention services across the state (similar to certified education counselors). A concern raised with this idea is that some areas of the state (such as rural and frontier communities) may lack the financial capacity to support certification or pay for certified prevention specialists, indicating that this may require a statewide funding approach.
- Work with Utah's higher education institutions to incorporate more training on evidence-based SUD prevention in their medical and behavioral health graduate education programs and/or consider adding certified crisis worker curriculum into training programs.
- Encourage state leaders (e.g., legislators, program directors, etc.) to complete prevention training to enhance their understanding of the science behind prevention activities.
- Fund and support an expanded prevention infrastructure at both the state and local levels (e.g., staffing, programming, etc.). This could include training to help people understand concepts and develop key components that are needed for delivering effective prevention programs and services (e.g., inclusivity, addressing risk and protective factors, developing safe and supportive policies and environments, providing referrals, and supporting access to care, etc.)

- Improve reimbursement for prevention services. This could include creating or updating codes for prevention services and ensuring health plans cover and reimburse them at sustainable rates (e.g., SBIRT, SDOH screening, etc.). Funding and supporting an expanded prevention infrastructure (as discussed above) would help ensure sufficient prevention services are available for access and referral.
- Create a central repository where health, behavioral health, child welfare, juvenile justice, courts, Adult Probation and Parole (AP&P), faith-based organizations, and the public could refer individuals and families to resources.
- Fund and support community coalitions while encouraging more collaboration. This could result in more targeted communication, education, and behavioral health prevention efforts. The state could consider developing or promoting a model or best practices for how these coalitions can work together and engage with different sectors.
- Create forums to share successes and best practices. These forums could help increase awareness of behavioral health needs within a community, what is working well to address them, and ways to help secure and sustain funding.

Community Coalitions

Community coalitions address targeted, local needs and seek to prevent the escalation of behavioral health issues by establishing connections with key community stakeholders such as courts, law enforcement, and schools.

COMMUNITY EDUCATION & SERVICES

Community education and services include behavioral health services provided in a community setting such as in schools, faith-based organizations, etc. The state has expressed dedicated support for community education and services through continued support of the SafeUT app and recent expansions of school-based mental health through the Elementary School Counselor Program (2018) and the Student Health and Counseling Support Program (2019).

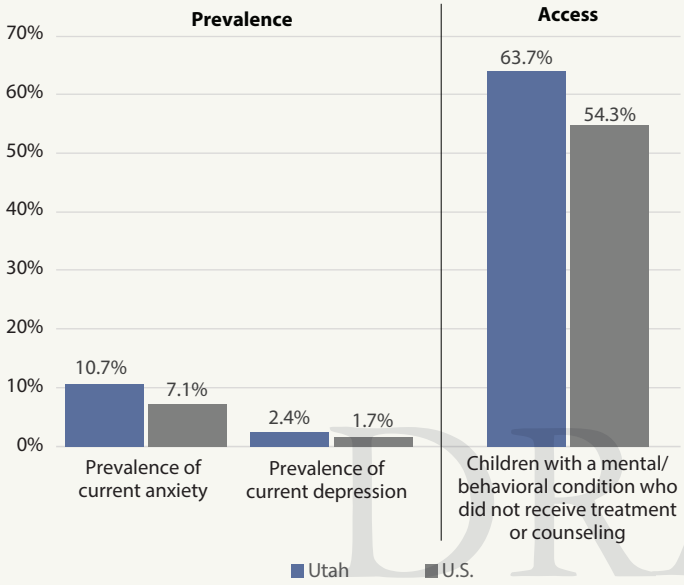
Gaps, Challenges, and Needs:

- *Duplication of effort and lost efficiencies between K-12 mental health services and supports and the broader behavioral health system.* Several discussion groups mentioned the unintended consequences the increase in school-based mental health professionals has had on the broader behavioral health system. Specific concerns relate to:
  - *Exacerbating workforce shortages.* Increasing the number of school-based mental health professionals resulted in hiring therapists, social workers, and other licensed mental health professionals from existing mental health providers and systems. "We ended up robbing Peter to pay Paul."
  - *Not utilizing school-based mental health professionals to the top of their license.* Participants were concerned that some licensed mental health professionals working in K-12 settings are focused more on school academics, class scheduling, and providing testing for individual education plans (IEPs). Addressing the state's current workforce shortages requires that mental health professionals be able to work to the top of their license.
  - *Not utilizing funding for its intended purpose.* It was noted that the state and local funding dedicated to this initiative was intended to be collaborative. Instead, it seemed as though some schools were not using the funding to support mental health, but rather academic school counselors who may not be fully tuned into mental health issues, training, and supports.
  - *A lack of appropriate training.* Participants expressed a need for the state to provide more guidance to school-based mental health professionals and school counselors regarding best practice approaches for providing behavioral health treatment in schools. It was also noted that better training could be provided on how to bill Medicaid (which other participants noted can be administratively burdensome).

Mental Health Needs Among Utah's Youth

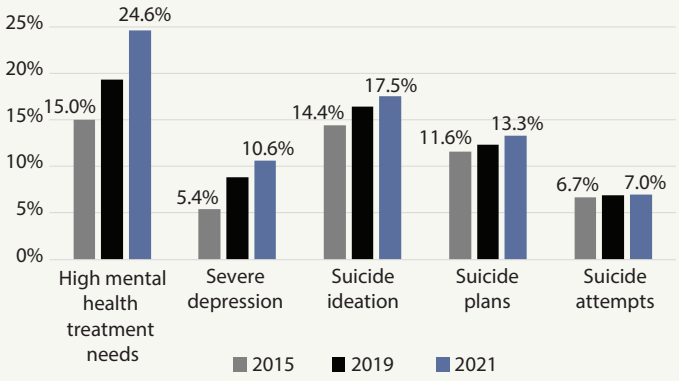
National research shows Utah is among a group of states with the highest prevalence of child and adolescent mental health disorders, and the highest prevalence of youth with untreated mental health needs.[61]

Figure 9: Select Mental Health Indicators Among Children Ages 6-11 in Utah and the U.S., 2020-2021 combined data



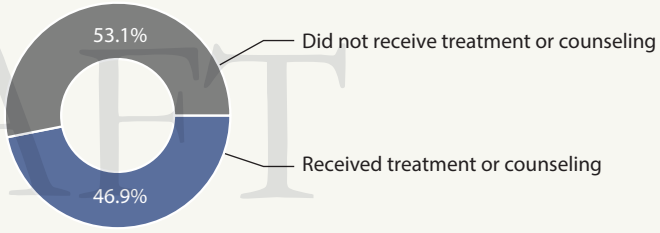
Note: The third column represent children reported by their parents to have been diagnosed by a health care provider with a mental/behavioral condition (depression, anxiety problems, or behavioral or conduct problems).
Source: Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 05/19/23 from www.childhealthdata.org.

Figure 10: Share of Utah Middle and High School Students with Mental Health Needs, 2015-2021



Note: Survey responses are from students in grades 6, 8, 10, and 12.
Source: Utah Student Health and Risk Prevention: Prevention Needs Assessment Survey. Utah Office of Substance Use and Mental Health.

Figure 11: Access to Treatment or Counseling for Utah Children with a Mental/Behavioral Condition Ages 12-17 in Utah, 2020-2021 combined data



Note: Data represent children reported by their parents to have been diagnosed by a health care provider with a mental/behavioral condition (depression, anxiety problems, or behavioral or conduct problems).
Source: Child and Adolescent Health Measurement Initiative. 2020-2021 NSCH data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, HRSA, MCHB. Retrieved 05/19/23 from www.childhealthdata.org.

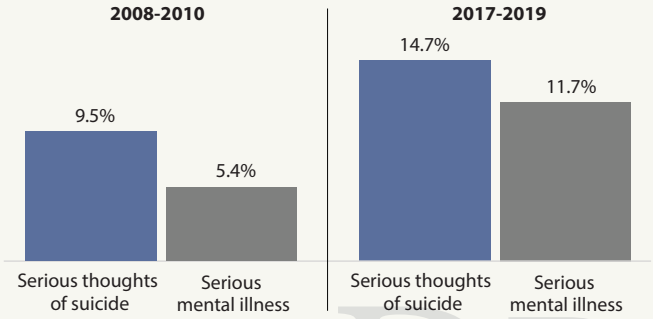
  - *A lack of connectivity to community behavioral health providers and the creation of a siloed system.* It was also noted that some school-based mental health professionals may only provide limited interventions and are not connected to or do not have access to the broader behavioral health system's robust continuum of care and specialty providers, including case managers, family peer support, and psychiatric prescribers (who are needed to treat more complex mental health issues).

- *Potential for duplication between higher education institutions' behavioral health services and the broader behavioral health system.* Utah's higher education institutions are experiencing escalating demand for behavioral health services (Figure 13 shows the share of young adults with poor mental health more than doubled over the last 10 years). Utah's public higher education institutions, including its technical colleges, are participating in the JED Campus program,[62] which is "a four-year collaborative process of comprehensive systems, program, and policy development with customized support to build upon existing student mental health, substance misuse, and suicide prevention efforts."[63] As these schools begin implementing their strategic plans, it will be important to connect to and leverage resources within the broader behavioral health system where possible to avoid adding to the system's current workforce shortages and creating more siloed systems.

Mental Health Needs Among Utah's Young Adults

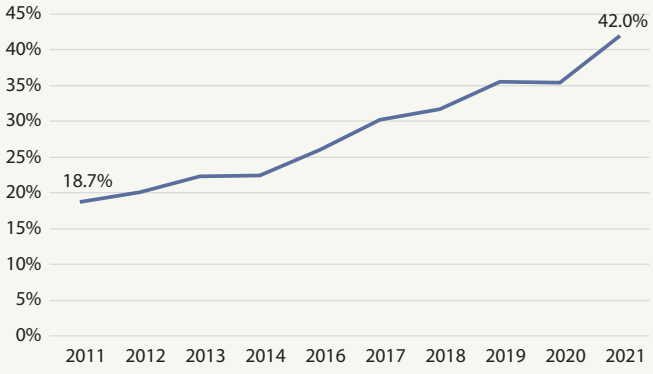
The percentage of young adults with serious thoughts of suicide in the past year has increased (9.5% to 14.7%) as has the percentage of young adults with SMI (5.4% to 11.7% from 2008–2010 to 2017-2019). Utah's rates are estimated to be higher than the national average, with the prevalence of young adults with SMI being statistically significant.[64]

Figure 12: Share of Utah's Adults Ages 18-25 with Select Mental Health Needs, 2008-2010 vs. 2017-2019



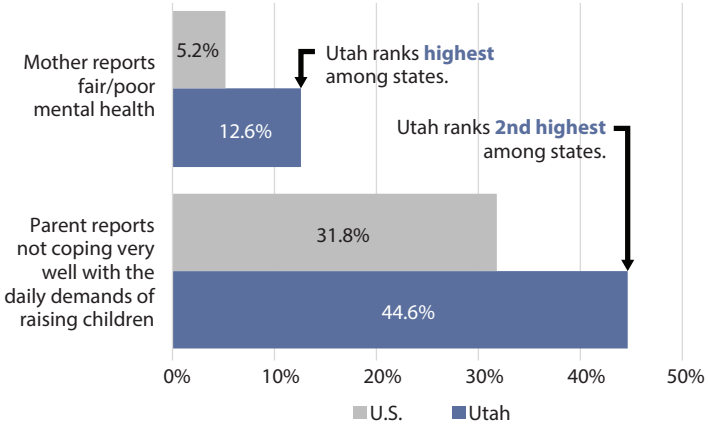
Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016–2019.

Figure 13: Share of Utah Adults Ages 18-25 With Poor Mental Health, 2011-2021



Note: Share of adults reporting seven or more days with not good mental health. "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.

Figure 14: Share of Children Under Age 3 with Mothers Experiencing Poor Mental Health in Utah and U.S., 2018-2020 combined data



Source: US Department of Health and Human Services (HHS), HRSA, MCHB. (2019-2021). 2018-2020 National Survey of Children's Health NSCH Public-Use Data. From Prenatal-to-3 State Policy Roadmap.

- *Improved connectivity with childcare providers and the infant and early childhood mental health system.* While opportunities for Utah's daycare, preschool, and other childcare providers to receive best practice training on infant and early childhood mental health are improving, it was noted that more coordinated work in this area is needed. It was also noted that, like the K-12 system, many childcare providers are not connected to the state's infant and early childhood mental health system (which, in many cases, is also not connected to the broader behavioral health system's continuum of care). It was also noted that creating this connectivity is more difficult in the childcare space than the K-12 space, given there is not a coordinated daycare, preschool, or childcare system.
- *Lack of behavioral health outreach services and supports.* It was specifically noted that behavioral health outreach services, like Stabilization and Mobile Response Teams, are not well-funded, which are important services for children with serious emotional disturbance (SED), as well as adults with SMI, individuals with SUDs, and individuals who have experienced chronic homelessness.

Bright Spots:

- *Some regions have adopted a collaborative approach to school-based behavioral health.* Central Utah Education Services developed a collaborative approach to addressing the mental health needs of its students and connecting to the broader behavioral health system. Using Teacher and Student Success Act (TSSA) funds and a mental health grant, the center hired a mental health coordinator that works with the local authorities to provide mental health services to its students. The coordinator applies a tiered approach to determine what level of behavioral health needs can be addressed by the school and what level should be referred out to the local authorities (who have access to the broader continuum of services). The result has been a decrease in suicides and better, more efficient use of mental health resources in the area.

Suggested Ideas for Next Steps:

- Improve collaboration between K-12 mental health services and supports and the broader behavioral health system by:
  - Providing more education or training on the roles/responsibilities of school counselors, school-based mental health professionals, and community mental health providers. "There is often a misunderstanding of what everyone does or should be doing, even among professionals."
  - Encouraging schools to develop agreements with local authorities and other community providers to align care needs and ensure access to the behavioral health system's continuum of care. The state could consider developing or promoting model language.
  - Creating systematic connections between community behavioral health providers and school-based mental health professionals. For example, multi-disciplinary teams could serve as intermediaries between schools and contract with (or have direct connections with) community behavioral health providers and/or DHHS.
  - Continuing to provide direct training and technical assistance to school-based mental health professionals, school counselors, and other staff. Note: some training efforts are already underway (e.g., suicide prevention training). It was noted that these efforts have helped reduce stigma among school staff and that future efforts include working with USBE to develop a document informing school professionals about appropriate suicide prevention screening methods. A concern related to this point is balancing this training with the increasing requests being placed on Utah's educators.
  - Implementing life skills building programs in schools, particularly in lower grades (e.g., Dialectical Behavioral Therapy (DBT) skills training).
- Provide funding and support for more home visiting programs to address infant and early childhood mental health as well as provide family support. Some discussion groups noted they would like to see more home visiting programs available to new mothers, particularly families with high behavioral health needs or other risk factors.
- Provide funding and support to programs that address childhood trauma and adverse childhood experiences (ACEs) including increasing public and private payers' coverage of these programs and ensuring they are reimbursed at sustainable rates.
- Create additional opportunities for implementing public-private partnerships with health organizations and foundations interested in supporting school-based services and the mental, emotional, and behavioral health of children and youth through programs and services that increase alignment between the public and private systems.

PRIMARY CARE BASED BEHAVIORAL HEALTH

Provider-Level Integration

Primary care based behavioral health is the provision of mild-to-moderate behavioral health care in the primary care setting, which is often the first point of contact for patients with mental health and SUD needs. Providing behavioral health services in this setting creates more access, better integration of physical and behavioral health, and opportunities for early intervention—preventing the escalation of behavioral health conditions and reducing crisis and emergency department (ED) utilization. Supporting primary care based behavioral health could also help alleviate the state's workforce shortages.

Gaps, Challenges, and Needs:

- *Limited screening and early identification of mental health and SUD.* Participants noted that limited screening for mental health and SUD (particularly in pediatric practices) prevents early identification of behavioral health needs and the ability to connect individuals to appropriate care before more acute care is needed. Challenges to implementing screenings stem from:
  - Low or no reimbursement.
  - Lack of training supports and primary care staff capacity to engage in screening.
  - Requests from health systems, advocates, and other stakeholders to consider multiple, different types of screening tools (which may not be supported by reimbursement).
  - Not having appropriate training or resources to address the risk and protective factors that contribute to mental health issues and SUDs in the primary care or pediatric setting (e.g., trauma-informed training).
  - Lack of access to specialty care when referral is necessary.
  - A lack of system coordination, including relationships between primary and specialty care to support referrals, and technology to support closed-loop referrals to behavioral health services, stabilization supports, and wraparound services.
- *Insufficient reimbursement.* To be successful— and incentivize physicians to integrate behavioral health services into their practice—physicians need to be adequately reimbursed for providing mental health and SUD services in a primary care setting. Some examples of services that are not well reimbursed include behavioral health screeners (as noted above), patient coordinators, care managers, etc.
- *Limited primary care-based SUD services.* While discussion groups generally acknowledged that primary care based mental health is improving, they noted that the provision of SUD services in a primary care setting is a gap in the system. This is due to a lack of prescribing providers across the state, particularly in rural areas where access to Medication Assisted Treatment (MAT) and Medication for Opioid Use Disorder (MOUD) is limited in both physician-based settings and in some jails for individuals who are incarcerated.

Gaps in Available Medication Assisted Treatment (MAT) or Medication for Opioid Use Disorder (MOUD) Programs and Support Services

Discussion group participants noted a lack of both waivered prescribers and licensed behavioral health therapists in most communities. The problem is magnified in rural areas where the nearest waivered prescriber, MAT program, or residential detoxification facility could be two or more hours away from a patient's residence.

Additional gaps and barriers to accessing MAT or MOUD noted by discussion groups include:

- Lack of places for formal induction of MAT
- Lack of prescribing physicians
- Lack of prescribing physicians willing to take Medicaid enrollees
- Lack of 24/7 prescribing physicians, walk-in centers, and pharmacy hours
- Shortages of available and affordable psychosocial therapists and behavioral health providers
- Waitlists for residential treatment programs that provide MAT
- Inadequate housing and a lack of other social supports to help people seeking treatment
- Lack of transportation, particularly in rural areas that do not have access to bus, taxi, or rideshare systems

It can be particularly challenging to attract and recruit physicians and licensed behavioral health providers in rural areas. Discussion groups noted the loss of even one prescriber or licensed behavioral health provider can be devastating. It can sometimes take more than a year to refill the position, which limits continuity and consistency in providing opioid use disorder (OUD) treatment.

Note: At the end of 2022, Section 1262 of the Consolidated Appropriations Act removed the federal requirement that practitioners must have a waiver to prescribe medications like buprenorphine to treat OUDs.[65] While this is a positive step in increasing access to MOUD, there is concern it will still be limited given primary care providers' lack of training in MOUD treatment, knowing how or where to engage patients in long-term treatment, and knowing how or where connect them to necessary recovery supports.[66]

Bright Spots:

- *Local collaboration.* Local collaborations that strengthen provider-level integration currently occur between Utah's community health centers, local authorities, and public and private health systems. For example, Utah's community health centers (federally qualified health centers) screen all patients for depression as part of providing comprehensive preventive care. Patients identified as at risk are often managed within the health center by the center's behavioral health providers using integrated delivery models, such as Primary Care Behavioral Health and Collaborative Care Management. Patients identified with behavioral health needs that are beyond the capacity of the health center are referred to the local authorities as needed, with the health center continuing to offer medical services to these patients. Several health centers have co-location arrangements with local authorities, further enhancing the ability to co-manage the health of patients with more significant behavioral health needs. Some health centers also collaborate with their local hospitals to accept referrals of patients being discharged who require additional behavioral health care that would be optimally provided in a primary care setting.
- *The VA (Veterans Affairs).* The VA also provides an integrated "no wrong door" approach to physical and behavioral health. Behavioral health services are integrated in the primary care setting through consultation and targeted referrals. Patients move fluidly through the system, receiving access to necessary physical and behavioral health services. That said, a Utah Rural Veteran Needs Assessment found that veterans in rural areas have a challenging time accessing necessary and appropriate services.[67]

Impact of Workforce Shortages on the VA

One point that highlights the state's workforce shortages is that the VA used to refer its patients to community providers when its own waitlists were too long, but waitlists in the community are now longer than the waitlists within the VA. This potentially creates access issues for veterans seeking care despite federal legislation expanding Veterans Health Administration (VHA) enrollees' access to VHA-purchased "community care."

Interestingly, a recent study found there was a greater presence of highly trained specialists treating veterans in the VHA compared with providers treating veterans in the community (22% vs. 10% of psychiatrists and behavioral neurologists and 25% vs. 18% of psychologists). There was also a greater presence of social workers in VHA (36% vs. 15%).[68]

- *Intermountain Health Mental Health Integration (MHI) Model.* The Intermountain Health MHI model is a team-based, whole-person approach to meeting the physical and behavioral health needs of patients and their communities. The focus is on patient engagement and shared decision-making, with care delivery led by the Primary Care Provider and supported by Care Management (Care Managers and Care Guides) and MHI Providers (i.e., LCSWs, Psychologists, APRNs, and Psychiatrists). "It's been such a blessing for so many people to see collaboration among their mental health [providers] and medical doctors." Intermountain is also implementing the Collaborative Care Model to further expand integration.
- *Expanding coverage and implementation of Collaborative Care.* Utah Medicaid, Medicare, TRICARE, PEHP, and several other private health insurance plans in Utah reimburse for Collaborative Care codes. As a result of this coverage, as well as increased education about the Collaborative Care Model, some providers in Utah are beginning to develop the necessary infrastructure to support the model and bill the codes. For example, the University of Utah recently launched its Collaborative Care initiative, which it has started to roll out across its system and in its community clinics.
- *Federal legislation.* Pending federal legislation (H. R. 5218) would incentivize primary care providers' uptake of the Collaborative Care Model.[69]

Collaborative Care Model

Collaborative Care is an evidence-based model of behavioral health integration that treats common mental health conditions such as depression, anxiety, and SUD. Primary care providers work with embedded behavioral health professionals (who can be unlicensed providers) to identify and treat behavioral health conditions with evidence-based brief interventions, care management supports, and use of a consulting psychiatric provider to improve primary care medication adjustment for patients who are not improving.[70] Collaborative care uses evidence-based treatment and tracks patient populations in a patient registry.

Discussion groups noted that more plans are covering the Collaborative Care codes, but provider uptake is low despite this being an initiative the state has been working on for several years.

Suggested Ideas for Next Steps:

- Provide better training to primary care practices on the provision of mild-to-moderate behavioral health treatment (participants noted that behavioral health training for physicians is often limited, e.g., 4-6 weeks). Discussion groups suggested:
  - Promoting or implementing uniform screeners across the system.
  - Providing more education and appropriate tools to pediatricians on how to recognize and diagnosis mental health needs in young children (e.g., DC:0–5™ the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood).
  - Providing training to behavioral health clinicians working in integrated clinics on how to provide brief physical health interventions and therapies.
- Improve physician support. Integrating behavioral health services in the primary care setting is a major process. "Primary care [physicians] can't do it all in a 15-minute visits." Specific ideas mentioned during the discussion groups include:
  - Developing and expanding technical assistance support for providers working to implement integrated or team-based approaches.
  - Developing enhanced referral networks to support primary care providers with screening and early identification and create connections to behavioral health providers for patients with complex behavioral health needs or chronic behavioral health conditions.
  - Continuing to provide statewide consultation support to primary care providers (e.g., the Psychiatric Consultation Program, or CALL-UP[71]).
  - Provide state-supported education, training, and technical assistance to primary care providers to invest in the Collaborative Care Model. Primary care collaborative models can be difficult to establish but have the potential to reduce the need for crisis and more acute services in the long term.

INTEGRATED PHYSICAL & BEHAVIORAL HEALTH CARE

Payer-Level Integration

This section focuses on the integration of physical and behavioral health. Discussion groups noted a desire to integrate physical and behavioral health in a way where behavioral health is not considered a specialty service, but part of a person's total "health care." This reduces stigma, improves access to care, and is a way to help address workforce shortages by creating efficiencies in the existing workforce.

Discussions focused on the need for integration at both the provider and the payer level. "Provider-level integration needs to be in place to support payer-level integration." Points related to provider-level integration are incorporated into the section above on primary care based behavioral health. They center on improving physician training on behavioral health issues and establishing team-based approaches to care. This section focuses on payer-level integration and system-level coordination.

"When the back end isn't integrated, it makes it difficult to do innovative things on the front end."

Gaps, Challenges, and Needs:

- *Payer-level integration of physical and behavioral health:* A common theme among the different discussion groups was the challenges stemming from a lack of physical and behavioral health integration. Some issues and concerns that were mentioned include:
  - The inability for providers to treat co-occurring physical and behavioral health issues.
  - Challenges for care management when an individual has separate payers for physical and behavioral health, often resulting in gaps in service information essential to support whole person approaches and coordination of care across providers.
  - The inability for patients to receive mental health and SUD services during a physical health visit, which creates barriers to access, increases the potential for two co-pays, and the reduces the ability for the system to establish a "no wrong door" approach to care.
  - A lack of system-level coordination (e.g., Utah Medicaid ACOs cover medication management, county health departments oversee prevention-related activities, different state and federal funding sources for SUD vs. mental health services, etc.).

- Medicaid payment disputes related to emergency psychiatric/SUD care provided in EDs and inpatient care. Local authorities are responsible for providing inpatient mental health benefits, whereas inpatient SUD benefits are the responsibility of the ACOs. The co-occurring nature of mental health and SUDs make this separation difficult from a reimbursement perspective (e.g., many people come to the ED both intoxicated and suicidal). Administrative law judge hearings can be used to determine who should pay when disputes arise about if the care was related to psychiatric or substance use care.

- *Mixed opinions on the effectiveness of the Utah Medicaid Integrated Care (UMIC) program.* The goal of the UMIC program is to increase payer-level integration in Medicaid. The program started January 1, 2020, and care is managed through integrated ACOs in five counties. Discussion groups had mixed opinions on its effectiveness. For example:
  - Several groups expressed concerns with the program, including: (1) A lack of data sharing between the ACOs and the local authorities and other providers, which limits their ability to coordinate care, manage services, and provide critical wraparound services for the SMI population. (2) ACOs not having necessary experience caring for the SMI population. (3) Changes in the administration of funding, which reduces the ability of local authorities to sustain the provision of critical crisis services, wraparound services, and community partnerships. (4) Reimbursement structures that do not account for SMI populations' treatment needs. (5) Burdensome procedures related to credentialing, reporting, and documentation requirements, billing, service denials, and prior authorizations.

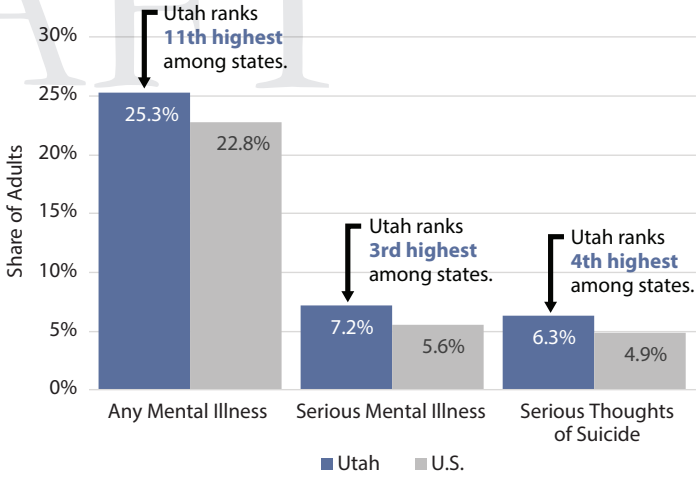
> *"The SMI population needs a behavioral health home."*

  - Other groups noted the benefits of the program including: (1) Improved ability for ACOs to coordinate physical health needs with behavioral health providers resulting in better care coordination for those with predominantly physical health needs. (2) Better provision of medication management for mental health and SUD needs. (3) Improved access to data at the ACO level. (4) Better use of integrated clinics within respective ACOs' systems. (5) The potential for broadening provider networks.

Administrative Challenges Related to Data Reporting

A problem that emerges with having multiple Medicaid programs is the ability to aggregate and share data between the state Medicaid agency, Medicaid ACOs, and the local authorities, which can create administrative challenges and inaccuracies in terms of data reporting. An example is a past Justice Reinvestment Initiative (JRI) audit that referenced legacy Medicaid data from the local authorities but did not include TAM or UMIC data, despite these programs being the largest public payers for the SUD criminal justice population. Having to access data from multiple programs creates an administrative challenge for state auditors, legislative analysts, and other program evaluators. The problem is further compounded by the inability to access and aggregate data from employer-sponsored and Marketplace plans that also cover services provided through the JRI. This restricts the ability to understand the full impact of this and other initiatives.

Figure 15: Adult Mental Health Indicators in Utah and the U.S., 2021



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

- *Continuity of care in Medicaid.* Another concern is the issue of "churn"—individuals moving between different Medicaid programs, different ACOs or prepaid mental health plans (PMHPs), and on and off Medicaid. This churn and changing eligibility disrupt a person's continuity of care. For example, a person who moves from the Targeted Adult Medicaid (TAM) program, which is administered by the Medicaid agency, and into a different Medicaid program could have to access a different provider network and set of

behavioral health services. An individual moving from public to private health care coverage would likely experience similar issues. It was noted that the discontinuity created by churn is particularly difficult for homeless individuals and individuals whose income just barely exceeds the levels necessary to qualify for the TAM program because these individuals lose access to the additional services and supports the TAM program provides.

- *System-level coordination:* Discussion groups also highlighted the need to think about improved system-level integration given the number of public and private behavioral health systems, providers, and state agencies that intersect with or are impacted by behavioral health issues. Examples include housing and homeless services, child welfare, services for persons with disabilities, schools, the court systems, criminal justice, law enforcement, etc. Challenges with this issue are discussed in the System-Level Issues section above.

Bright Spots:

- *Medicaid continuous coverage of the Targeted Adult Medicaid (TAM) population.* The TAM program provides Medicaid services to a capped number of adults without dependent children who are: (1) chronically homeless; (2) involved in the justice system through probation, parole, or court ordered treatment needing substance abuse or mental health treatment; and (3) needing substance abuse treatment or mental health treatment. The TAM program offers beneficiaries 12 months of continuous coverage.

Suggested Ideas for Next Steps:

- Consider establishing continuous eligibility in Medicaid to prevent people from switching programs more than necessary. "It is very confusing for patients to be dropped from Medicaid every six weeks."

Utah's Behavioral Health Delivery Workgroup

H.B. 413 (2022) requires DHHS to convene a working group to discuss the delivery of Medicaid behavioral health services, specifically behavioral health services provided to individuals in the TAM program. This working group met throughout 2022 and will continue to meet in 2023. DHHS is reviewing the different options considered by the group.

- Continue to study policy, program, or statute changes to reduce barriers created by the state requirement that Utah's county governments match Medicaid behavioral health services.
- Engage in further evaluation of the UMIC program to address challenges providers currently experience related to timely reimbursement and burdensome procedures (e.g., credentialing, billing, service denials, and prior authorizations). Consider ways to improve public accountability, ensure transparency, and increase provider sustainability.
- Consider establishing shared system incentives for achieving positive outcomes to encourage continuity of care both within Medicaid and between Medicaid and other payers.

OUTPATIENT SPECIALTY SERVICES

A key issue that emerged in several discussion groups was the lack of access to high-quality outpatient behavioral health services (i.e., behavioral health services provided by the licensed mental health workforce in an outpatient setting such as community mental health centers, offices, clinics, etc.). Not being able to access effective and appropriate services in an outpatient setting can exacerbate behavioral health needs, requiring people to access services in more acute care settings.

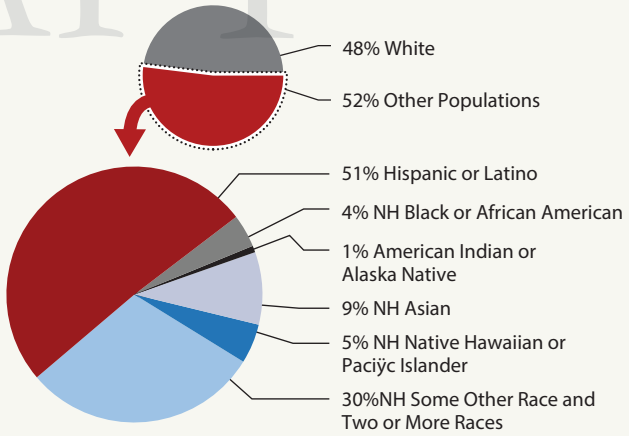
Gaps, Challenges, and Needs:

- *Limited access.* The lack of access to outpatient specialty services stems from a myriad of issues, including more people needing behavioral health services due to the state's rapid population growth, Medicaid expansion, lessening stigma, improved access to crisis services (i.e., receiving centers and MCOT teams), workforce shortages (worsened by the COVID-19 pandemic), administrative burdens, limited reimbursement, a lack of system coordination, and the creation of system siloes. Specific examples of gaps in outpatient specialty services that were mentioned in different discussion groups include:
  - Psychiatrists.
  - Rural-area providers (need spans all specialties).
  - Tribal area providers (need spans all specialties).
  - Language accessible and culturally literate providers, representative of different communities and populations, with a focus on Spanish-speaking therapists and interpreter services. Some groups also noted the desire for Medicaid to reimburse for more culturally appropriate, but non-traditional behavioral health services (Arizona is an example).
  - Providers who are qualified to treat persons with co-occurring conditions, with a focus on ID/DD and persons with autism spectrum disorder (ASD). Note: Reimbursement for these services come from different funding streams and state agencies, which creates challenges in developing this workforce. Private health insurance also does not typically reimburse for ID/DD services.
  - Therapists who accept court-ordered treatment (resulting in a current backlog of juvenile court cases). Note: private health insurance plans may place limits on the number of covered sessions, which could impact a person's ability to complete court-ordered treatment.
  - Providers who are qualified to treat persons experiencing homelessness (including peer support specialists and certified case managers). "Individuals that are homeless face insurmountable barriers simply meeting their survival needs, let alone the ability to engage in treatment above and beyond these needs." "Individuals experiencing homelessness shouldn't have to end up in the criminal justice system to get support."
  - Providers who are qualified to treat geriatric behavioral health, including intensive outpatient programs (IOP), and providers who are qualified to treat early childhood, child, and youth behavioral health issues.
  - Assisted Outpatient Treatment (AOT) due to limited reimbursement.

Diversity in Utah's Behavioral Health Workforce

White/Caucasian providers continue to make up a disproportionate share of Utah's mental health workforce compared to the overall population. That said, the workforce has become slightly more diverse since 2016. The proportion of White/Caucasian providers decreased from 92.5% to 88.5% of the workforce. The largest increase was in respondents who are multi-racial or self-reported an "other" identity, up 1.1% from 2016.[72]

Figure 16: Contributions to Population Growth by Racial and Ethnic Populations, 2010 to 2020



Source: Kem C. Gardner Policy Institute

- *Quality and outcomes:* As noted above, some studies estimate that only 40% of persons receiving behavioral health care benefit from the treatment received.[73] [74] As also noted above, discussion group participants want to feel that "recovery is possible." Having access to high-quality and outcomes-based services, supports, and interventions can help people achieve recovery. That said, moving high-quality, evidence-based treatment into routine practice is difficult and there are practical and preferential barriers to implementation, including time and resources. One study shows that it takes nearly two decades to move less than

14% of evidence-based research into practice.[75] Continuing the use of valid and reliable measures that are already in use (e.g., Outcome Questionnaire, Functional Outcome Survey, Brief Addiction Monitor, Substance Use Recovery Evaluator (SURE), etc.) provides an opportunity to scale measurement-based care and improve safety and outcomes within an existing infrastructure that can be expanded in the future.

- *Restricted choice.* Some discussion groups also mentioned a need for more choice when accessing outpatient specialty services. Challenges related to "choice" seem to stem from a lack of coverage. For example, a few groups expressed concern that some public and private payers do not contract with community providers. This limits access and choice—particularly to providers that may have more expertise in treating specific populations such as historically marginalized or underserved communities.
- *Navigating the complexity of private health insurance coverage and reimbursement of behavioral health services.* As noted above, limited health insurance coverage and reimbursement for behavioral health services contributes to challenges with access and choice. The complexity of navigating private health insurance plans, both from a provider and patient perspective, contributes to this issue as well. For example, the fact that different plans cover a wide range of different services, impose different coverage restrictions, and negotiate different costs, makes it difficult for patients to navigate the system and for providers to make appropriate referrals and provide transition supports (particularly when a patient is in crisis). Individuals with HDHPs may more acutely feel a lack of choice, given they are likely paying more out of pocket for behavioral health services.
- *Sustainable funding.* In addition to better access and more choice, it was noted that more funding is needed to support outpatient services. Many community-based providers, particularly those that serve historically marginalized or underserved communities, currently use grant dollars to support their operations and services but have to figure how to sustain these operations once the grant funding ends. Many of these providers are also nonprofit organizations that do not have the capacity or resources to handle the increasing demand they are currently experiencing. Higher reimbursement and/or alternative payment methodologies that provide sufficient reimbursement for variety or bundle of services are needed from both public and private payers to sustain these and other providers and improve access to care. "Grants, legislatively appropriated funding, and federal funding are not sufficient to support the current need for behavioral health services in Utah."
- *Services for Persons with Co-Occurring Conditions.* Improving access to services across the behavioral health continuum for individuals with co-occurring conditions, particularly ID/DDs, was mentioned in many of the discussion groups. It was noted that the need spans from those with lower acuity conditions—who can and want to be seen in the community—to those who need inpatient or residential care. In both situations, these individuals may need access to different spaces and treatment techniques, which can be difficult for facilities to accommodate. Discussion group participants noted that, as a result, these individuals can be denied care and have a difficult time accessing the treatment they need. This unfortunately has given the perception that behavioral health providers are unwilling to treat people with additional disabilities or co-occurring conditions.

Behavioral Health Issues are not Acute Health Issues

Some discussion groups noted the need to recognize that behavioral health issues often cannot be treated and reimbursed like acute care issues. Doing so leaves the consumer paying for services out of pocket or places the burden on the public system to find ways to provide underinsured individuals with ongoing services and supports due to a person's inability to pay.

A related concern is that people who run into coverage limits or need additional services may end up in the crisis system and then the public system to receive necessary care. This makes Utah's publicly funded behavioral health system the de facto payer of behavioral health services in the state.

However, Coverage Seems to be Improving

Some participants did note that private health insurance coverage of behavioral health services has improved due to more large employers recognizing for the need for comprehensive physical and behavioral health care coverage as well as better enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA). For example, Utah's Insurance Department reviews health insurance plans for MHPAEA compliance prior to authorization.

> *"30–50% of individuals with an ID/DD have a co-occurring mental health diagnosis."*[76]
>
> While people with ID/DDs make up about 1% of the U.S. population, they are disproportionately impacted by mental health issues. Rates of ID/DD also increase with age. About 10% of Utah adults have a cognitive disability.[77] Concerns related to this access for this population include:
>
> - DSPD's current waitlist. Individuals on this waitlist often have accompanying mental health issues or SUDs but they are unable to stabilize without the ability to concurrently receive DSPD services. As a result, they "frequently bounce through systems, including the criminal justice and homeless systems, adding costs to these systems and the taxpayer." There was also concern about how the waitlist prioritizes people based on their need. Some higher-functioning individuals, particularly adults, are left with no access to services.
> - Caps on Medicaid waiver participation and funding for persons with disabilities.
> - Private health insurance plans often do not reimburse for services related to ID/DDs and only some services related to ASDs (for children ages two to nine).[78]
> - There is a lack of services for elderly and other patients with dementia that have co-occurring behavioral health issues.
> - An area for further exploration is whether the need for these services is due to the lack of behavioral health services or unmet need through DSPD (i.e., what type of service is most needed, behavioral health or ID/DD-focused).

- *Services for persons who are incarcerated.* Improving access to behavioral health services for individuals who are incarcerated was also mentioned in the discussion groups. These discussions primarily focused on:
  - Improving continuity of Medicaid coverage and data sharing between Medicaid programs. Note: federal regulations limit the coverage Medicaid can provide while someone is incarcerated. As such, alternative sources of funding may be needed to ensure access and continuity of care while individuals are incarcerated.
  - Eliminating the delay individuals leaving prison experience before enrolling in Medicaid (which can be up to 30–45 days). Participants noted that the biggest barrier is the waiting period required after a person is released from prison and placed on parole.
  - Improving data collection to help ensure continuity of services. For example, the state currently has an agreement with the University of Utah that persons leaving jail can access Medicaid-covered services at University of Utah hospitals and clinics. Problems arise, however, with individuals who cycle in and out of correctional facilities and are difficult to connect to follow-up care. Information is also self-reported, which results in missing information.
  - Improving funding to sustain and expand effective, evidence-based programs that reduce recidivism by addressing behavioral health needs (e.g., Salt Lake County's Life Skills and CATS (Correctional Addiction Treatment Services) programs). For example, discussion groups estimated that if AP&P Treatment Resource Centers[79] billed Medicaid for services (and leveraged Medicaid's federal participation), it could save 60-70% of their state general fund dollars.

Bright Spots:

- *SUMH's multi-cultural affairs grant.* SUMH provided over $1 million in grants to community organizations. This funding allowed grant recipients to expand services, including medication and wraparound services such as childcare. SUMH provided technical support to grant applicants and worked closely with recipients to co-create solutions that were tailored to their specific populations and needs. Discussion groups noted that more funding like this is needed to help sustain the system—funding that is flexible, comes with technical assistance, and adheres to best practices.
- *Flexible reimbursement*. In addition to flexible funding provided through SUMH's multi-cultural affairs grant, it was noted that some local authorities are working to provide reimbursement when a patient is a no-show. The lack of reimbursement for no-shows is particularly difficult for nonprofit and community providers who serve historically marginalized and underserved communities. Many of these patients require interpreter services, which must be paid for even if a patient does not make their appointment.
- *Targeted Adult Medicaid (TAM) program.* Utah is engaged in a Justice Reinvestment Initiative (JRI),[80] designed to keep low-level offenders out of prison. As part of this process, funds were needed to expand community behavioral health treatment to help divert re-offenders and connect them to treatment. Some discussion group participants noted, however, that while the JRI passed in 2015, the intended funding mechanism for treatment (Healthy Utah, one of the Medicaid expansion plans), did not pass the House.

The local authorities instead received limited dollars, meeting only a fraction of the need. Additional JRI dollars were appropriated in 2016 but continued to serve only a portion of the criminal justice population. The TAM waiver, approved in 2017, became the largest payer for criminal justice involved individuals with a SUD as the primary condition. This funding allowed community treatment providers to more than triple SUD residential capacity in Salt Lake County, while also expanding other levels of care (the program is based in fee-for-service, meaning it is open to "any willing provider"). As noted above, the waiver allows an individual to remain eligible for a one-year period and allows for Medicaid reimbursement for SUD services provided in programs with more than 16 beds (i.e., an IMD, institutions for mental diseases, waiver). The TAM program has received national recognition.

- *1115 waiver: Medicaid Coverage for Justice-Involved Populations.* The state has an 1115 waiver pending approval from the Centers for Medicare & Medicaid Services (CMS) that would allow Medicaid coverage 30-days prior to an individual being released from a correctional facility. Individuals must have a chronic physical or behavioral health condition, a mental illness as defined by Section 62A-15-602 of Utah State Code, or an opioid use disorder.[81] Having coverage prior to release would eliminate the waiting period referenced above and help reduce the lag time between when a person's application is approved and when they can start accessing services (retroactive eligibility).

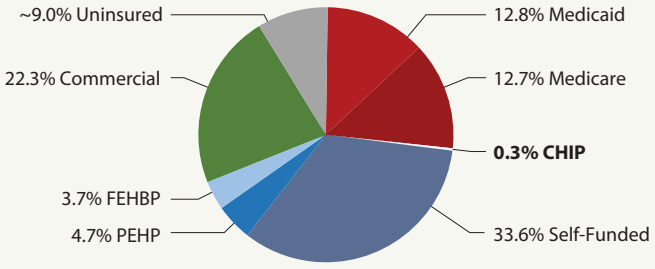
Suggested Ideas for Next Steps:

- Seek legislative support for a Medicaid data management system to help improve access to services for persons who are incarcerated.
- Encourage employees with HDHPs to contribute more to HSA/flexible spending accounts and provide education on the access points and costs related to behavioral health services.
- Increase behavioral health safety-net funding. Establish a legacy fund that could grow in perpetuity and support high-need areas.
- Incentivize businesses to focus on behavioral health. By helping businesses understand the importance behavioral health, they will seek health insurance plans that cover a broader range of behavioral health services.
- Establish more behavioral-health focused value-based or alternative payment models (can help address reimbursement issues experienced across the continuum of care).
- Develop a forum or coalition for private health insurance companies to discuss behavioral health issues (e.g., a subgroup or group connected to the Utah Health Insurance Association, UHIA). Discussion groups noted that health plans could benefit from a collaborative and aligned approach to behavioral health. Developing a collaborative path forward would hopefully reduce the need for legislative mandates, which negatively impact private health insurance plans and push more employers into self-funded plans. The collaborative could promote a common approach to physical and behavioral health integration efforts as well as help drive the use of value-based payment models.
- Promote evidence-based treatment. Some discussion groups noted that the way to improving care quality is finding ways to measure improvement and focus on recovery. Others suggested developing an outcomes dashboard. This could help ensure evidence-based practices are adopted with fidelity. Others noted that providers who engage in evidenced-based practices "should be prioritized and paid more."

Utah's Health Care Coverage Landscape

While Medicaid and the public health system are important payers of behavioral health services, most people in Utah have private health insurance coverage. The majority of Utahns receive health care coverage through their employers (~60%) and Utah has the highest rate of employer-sponsored insurance (ESI) in the country.[82]

Figure 17: Estimate of Health Insurance Coverage, 2021



Source: 2022 Utah Health Insurance Market Report, Utah Insurance Department.

CRISIS/DIVERSION SERVICES

Improving the state's crisis and diversion services was a strong focus of the 2020 Roadmap and many of the discussion groups mentioned this as an area that has generally improved. Many positive comments were made about the state's recent and current efforts to develop and expand MCOTs and community-based behavioral health receiving centers (located in Davis, Salt Lake, Utah, and Washington counties, with more being planned and built). That said, a few gaps and challenges remain.

Gaps, Challenges, and Needs:

- *Rural-area crisis services:* Many rural area participants expressed a desire for more crisis/diversion services. Even with the statewide expansion of MCOTs, participants noted the difficulties of deploying, accessing, and sustaining MCOTs in Utah's rural and frontier areas, including long wait times, distance and barriers created by geographical terrain, and limited staffing. For example, these services typically need to be available 24/7, which results in a high average cost per crisis, but the avoided cost of police involvement and emergency care is not recognized when calculating direct costs.
- *Sustaining crisis and diversion services.* Beyond the challenges related to establishing rural-area crisis services, it was noted that crisis and diversion services, in general, could benefit from more alternative payment methodologies. For example, Medicaid reimburses receiving centers through a lump sum or bundled payment, while private health insurance plans reimburse for discrete services. The bundled payment better encompasses a variety of necessary services and allows for more flexibility, which is important when addressing patients with a variety of crisis needs.
- *Receiving, access, and other crisis/holding centers.* Discussion groups also noted that receiving centers are basically non-existent in rural areas, which places a heavy burden on law enforcement as well as reduces the ability to divert individuals to appropriate behavioral health services. It was noted that police officers in rural areas often take people to the ED, which requires police monitoring. The time this takes, coupled with an increase in behavioral health-related incidents, is negatively impacting law enforcement's ability to serve the community and engage in other activities.
- *Social detox services/facilities.* A few discussion groups noted the need for more social detox and other types of ambulatory withdrawal management services. These programs engage individuals when care is most needed and move them to appropriate levels of longer-term or higher-acuity care. That said, many of these programs and services are not supported by private health insurance plans and are unaffordable for most consumers. This makes it difficult to provide these services in smaller communities. There was also confusion regarding what components of social detox services are covered by Medicaid. Finally, it was noted that many residential centers cannot take patients in withdrawal, meaning individuals are unable to access care unless they can show evidence of being sober.
- *A lack of coordination with the justice system.* Utah's court system is using the Sequential Intercept Model (SIM)[83] to understand how individuals with mental health and SUD come in contact with and move through the criminal justice system. It was noted that Utah's courts currently get involved at intercept 3 (jails/courts) but would like to see offenders engage in treatment at the earlier levels. The biggest gap is in levels 0-1 (community services and law enforcement), although it was noted that there are currently not enough resources to address diversion at levels 0, 1, and 2 (initial court hearings/initial detention). It was also noted that funding often only attaches at levels 3, 4 (reentry), and 5 (community corrections). As a result, the court system needs better access to upstream services and existing diversion services.
- *Training and education of law enforcement.* In general, there was a perception that law enforcement needs to be better educated about mental health episodes and SUDs. This is particularly true for defendants who commit low-level offenses, but have high behavioral health needs (e.g., individuals who cycle through jails, homeless shelters, and EDs and require mental health services to end the cycle). While receiving centers and MCOTs have helped address some of these issues, participants noted that many mental health cases still end in arrest. For example, mandatory arrests for domestic violence offenses may encourage families not to call the police because they do not want an arrest to be made. It was also noted that there needs to be better standards when it comes to pink sheeting. A consistent set of standards is not used across the state, meaning the decision is often left to the police officer on duty. That said, groups like the Crisis Intervention Team Utah are working to bring together law enforcement, mental health professionals, and mental health advocates to improve community responses to mental health crises.[84] They provide best-practice certification and training.

Bright Spots:

- *Current and ongoing development of receiving centers and the expansion of MCOTs.* Discussion groups noted improvements to the state's crisis and diversion services with the establishment of the receiving centers and MCOTs. Participants appreciated the safe space they provide people experiencing mental health and SUD crises. Participants also appreciated that some of the receiving centers are being developed with input from those with lived experiences and felt that more of this input is needed in the development of behavioral health services and supports.
- *Establishment of 988 and the Utah Behavioral Health Crisis Response Commission.* 988, a nationwide 3-digit number for mental health crisis and suicide prevention services, went into effect in July 2022. S.B. 155 (2021) established Utah as a leader in these efforts by creating a 988 restricted account, requiring the Division of Medicaid and Health Financing to adopt or apply for a state plan amendment or waiver to support crisis services (including the crisis line), and adding additional members to the Crisis Response Commission. The commission is currently developing recommendations for expanding Utah's crisis system in a way that is designed for anyone, anytime, and anywhere. Key goals include better care, hospital diversion, and law enforcement/jail diversion.

Suggested Ideas for Next Steps:

- Provide more education and awareness of crisis and diversion services. This could include promoting crisis resources as well as training law enforcement and related agencies on the availability and details of MCOTs and receiving centers (e.g., a referral is not needed).
- Address rural area crisis/diversion service challenges. Possible solutions include: (1) considering alternative models by leveraging telehealth or co-location with rural-area hospitals or providers (it was mentioned that the idea of using telehealth providers to assist with rural situations had been proposed but had not gained traction due to limited reimbursement); (2) using social workers to assist with more crisis situations; and (3) considering alternative payment models to help sustain both rural and urban area crisis/diversion services.
- Connect the state's court system to existing prevention and diversion services and ensure sufficient services are available for the court system, particularly rural-area courts.
- Develop consistent payment sources for funding, sustaining, and expanding crisis/diversion services across the state.

SUBACUTE CARE, ACUTE/INPATIENT CARE, AND RESIDENTIAL CARE

For purposes of this report, subacute care includes a variety of long-term services and supports provided in a non-acute hospital or other long-term care setting for people recovering from an acute mental health disorder or SUD who need more targeted care. There is a range of subacute services, including partial hospitalization and other intensive outpatient services, as well as subacute hospital care. A common theme among discussion groups was the need for more subacute care options—both across the state of Utah and especially in rural areas—and it was highlighted as a gap in the continuum that exists both in front of and behind acute inpatient care.

This section also provides information on acute/inpatient care, including residential, since many of the gaps, challenges, and needs are interconnected. Acute/inpatient care is defined as inpatient behavioral health treatment and stabilization.

Gaps, Challenges, and Needs:

- *Fixing the front end.* A predominant theme among discussion groups is the lack of services for individuals needing more than crisis and diversion services, but something less than acute or inpatient care. For example, some of the discussion groups noted the lack of services that exist between receiving centers and inpatient care, or between social detox and inpatient care. It was also noted that the existing programs' capacity is insufficient for the state's growing needs. Rural areas also noted a lack of access to "step up" facilities, particularly for individuals that do not meet State Hospital criteria, but have higher acuity needs than what can be provided in the community.
- *Fixing the back end.* Another predominant theme is the lack of "step down" services or intermediate care facilities for people moving away from high-acuity, inpatient care, but who need more than what is available through outpatient or community services in their area. It is important to note that this gap contributes to the capacity issues experienced by inpatient care facilities as a lack of appropriate step-down care facilities and community-based resources delays the ability to discharge patients.

  It was also noted that the lack of step-down facilities prevents long-term recovery. If no step-down services are available upon discharge, many patients experience a return of acute symptoms resulting in a return to higher levels of care despite the previous gains from high-quality care being provided in the acute or inpatient setting. There was also

a general consensus that most patients are best served in their community, but this least restrictive approach is only viable if services are available.

Step-Down Facilities

Discussion groups noted several gaps related to step-down facilities:

- Skilled nursing and other residential facilities for behavioral health needs.
- Sober living.
- Partial hospitalization programs (PHP) and IOP coverage.
- Step-down care referrals from the ED.
- Subacute services for those being discharged from inpatient care facilities but still needing intensive or residential care.

Acute/Inpatient Facilities

Specific examples of geographies and populations in need of acute/inpatient facilities include:

- Utah's rural and frontier areas.
- Geriatric populations with neurocognitive complexity (e.g., schizophrenia). It was noted most nursing facilities will not serve this population and many behavioral health providers are not qualified to provide necessary services.
- Individuals with ID/DD. It was noted these individuals often receive treatment at the Utah State Hospital but can be difficult to discharge given the lack of available services in the community.
- Options for people who are violent or aggressive, but not in the criminal justice system and are unable to be placed in residential treatment. It was noted that many of these individuals are held in EDs, "fail-out" of private facilities, and are family challenged.
- A small set of youth with highly complex behavioral health needs (e.g., dangerous behaviors, self-harm, severe conduct disorders, etc.) that cannot be placed in the community. Most are institutionalized as adults.

- *Low reimbursement and limited coverage.* As noted above, low reimbursement and limited coverage of behavioral health services limit both access and choice, particularly for subacute, acute/inpatient, and residential services. Several groups noted that a main barrier to creating and sustaining these facilities is how they are governed and reimbursed. Participants discussed: (1) Medicaid reimbursement being too low; (2) federal regulations limiting reimbursement for institutions for mental disease (IMDs) being too restrictive; and (3) private health insurance plans imposing too many limits on services and reimbursement. Specific examples of issues and concerns include:
  - Reimbursement and coverage variability across payers dictating treatment quality. Payers changing contract terms without notice also makes it difficult to provide consistent care.
  - Limits on coverage resulting in treatment disruptions. For example, a person may be discharged from residential care sooner than they should due to their health plan's coverage limits. This restricts their ability to stabilize in a residential or acute care setting. Constant utilization reviews are also disruptive.
  - Limited-to-no funding being available to support unfunded or uninsured populations. "We haven't raised our self-pay rate in 10 years."
  - Patients' acuity levels not aligning with payment. "Medicaid and TAM pay a quarter of what commercial health insurance does."
  - Low Medicaid reimbursement making it difficult for acute, inpatient, and residential care facilities to operate with sufficient margins, which disincentivizes new facilities from entering the market. Some facilities located in Utah do not provide services to Utah residents. "Utah has the most residential beds per capita but least access to those beds."
  - Medicaid covering treatment provided in an acute, inpatient, and residential setting, but not room and board. Some SUD federal block grants can help cover room and board, but reimbursement is difficult.
  - Burdensome procedures related to credentialing/paneling, billing (e.g., exclusions on same-day billing), service denials, reporting and documentation requirements, and prior authorizations.

Bright Spots:

- *Increased capacity at the Utah State Hospital.* H.B. 35 (2020) provided funding to open 30 additional beds at the Utah State Hospital. This funding was pulled back due to the COVID-19 PHE but was reinstated in 2022. The state also authorized increased pay for Utah State Hospital staff, which has helped address some of the hospital's workforce needs.
- *Utah Medicaid IMD waivers***.** In 2019, the state's SUD and opioid services IMD waiver was approved by CMS. This waiver allows Utah Medicaid to reimburse SUD residential treatment centers with more than 16 beds.[85] H.B. 219 (2020) required the state to submit a mental health IMD waiver, which would also allow Utah Medicaid to reimburse mental health residential treatment centers with more than 16 beds for stays less than 15 days. The waiver was approved by CMS in 2020. Participating entities are required to receive accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission. As noted above, some discussion group participants indicated a desire for more flexibility from CMS regarding restrictions in the mental health IMD waiver.
- *Increasing step-down or interim care facilities.* The state is currently exploring how to incentivize some nursing home facilities to provide step-down or interim care for state hospital and other patients who require long-term custodial care. This includes examining how to provide this benefit to Medicaid enrollees, whether and what level of appropriation would be required, obtaining CMS approval, and how to expand these types of services to group homes.
- *State Hospital long-term care facility.* The state is also exploring the development of a long-term facility at the Utah State Hospital that could serve both forensic and NGRI (not guilty by reason of insanity) populations that require lower-level acuity services but cannot be discharged into the community. The model is based on a facility in New Mexico and would be "a more structured community-based-like setting." It would be state funded, but not certified for Medicaid or align with the IMD waiver.
- *HMHI HOME Program.* The Neurobehavioral HOME Program (Healthy Outcomes, Medical Excellence) at the University of Utah is an outpatient clinic that provides mental and physical health services to Medicaid enrollees who are dually diagnosed with a developmental disability and a mental illness.[86] The program was built on the idea of blending medical and mental health funding streams for people with developmental disabilities to provide continuous clinical services to meet their complex medical and mental health needs.

Need for More Community-Based Services

While needed, it is important to note that the development of additional interim or long-term care facilities will not address the need for services for populations who are able to transition to community-based facilities but cannot because of a lack of access. It also does not help with Olmstead requirements and meeting the goal of community integration.

Suggested Ideas for Next Steps:

- Address the Mental Health IMD gap and improve per-diem rates. This could include first establishing continual inflationary adjustments for Medicaid behavioral health rates. Beginning July 1, 2022, S.B. 161 (2021) requires an inflationary increase for Utah's Medicaid PMHPs. DHHS is currently evaluating whether state statute amendments are needed to include Medicaid behavioral health funding in the Medicaid consensus process (this process takes into account caseload growth and changes in the Federal Medical Assistance Percentages, FMAP). Additional clarification may be needed for this recommendation to be fully realized.
- Encourage additional value-based care arrangements, shared risk models, and bundled payment arrangements to cover the costs of subacute levels of care as alternatives or step-downs from inpatient care.
- Consider establishing mental health crisis respite homes. These "homes" exist in residential settings and provide short-term crisis services. An example model are the homes established by the Georgia Department of Health and Developmental Disabilities. "Each home serves up to four individuals who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions. Placement in Crisis Respite Homes occurs when individuals have not responded to less restrictive crisis interventions."[87]
- Develop an independent review board to manage concerns providers have with private health insurance plans related to subacute, acute, inpatient care, and residential behavioral health care coverage and reimbursement.

STABILIZATION SUPPORTS AND WRAPAROUND SERVICES

Stabilization supports and wraparound services are support services that allow people to manage their condition in their home or community. These services and supports vary on an individual basis and are tailored to address a person's behavioral health needs as well as the social determinants of health. Examples include case managers, supportive housing, day treatment (e.g., clubhouses), employment assistance, transportation, informal support systems, etc. Coordination of these services is critical and can be enhanced through digital connections, improved cross-system communication, and integrated services.

Gaps, Challenges, and Needs:

- *Care coordination, transition support, and patient navigation.* As noted above, findings from the environmental scan indicate a strong need to improve system-level coordination, which is a key contributor to the state's challenges with establishing and maintaining effective care coordination, transition support, and patient navigation systems. These systems help providers make appropriate and timely referrals (both within and across systems), assist with care transitions, and engage in discharge planning (e.g., provide warm hand-offs)—as well as support patients in navigating the system.
- *Housing.* Housing was mentioned in nearly all discussion groups as a key gap in Utah's behavioral health system. Discussion groups noted that there are insufficient housing vouchers and other assistance available to address the state's growing needs. And while the local authorities provide critical housing support services, they operate with limited resources in a increasingly expensive housing market. Despite being an external issue to the behavioral health system, the lack of housing stock, affordable housing, and homes that are affordable is disrupting care across the behavioral health continuum—impacting patients and providers. For example, the issue:
  - Creates stress and instability that negatively impacts a person's behavioral health and well-being.
  - Limits the ability for the system to provide necessary services such as permanent supportive housing, particularly in rural areas.
  - Exacerbates the state's existing behavioral health workforce shortages. Behavioral health systems across urban and rural areas noted that they are unable to attract talent to their areas due to the lack of homes that are affordable.
  - Increases homelessness and lengths of stay in shelters, community group homes, recovery centers, and other supportive housing programs. This exacerbates the challenges related to "step-down" care mentioned above and the ability to discharge patients from acute/inpatient care settings.
  - Prevents people in the criminal justice system from effectively participating in court-ordered treatment.
- *Other supportive services.* In addition to housing, discussion groups noted gaps in other supportive services including:
  - Case management, family peer support, and therapeutic behavioral health services (e.g., skills training).
  - Transportation, particularly in rural areas (e.g., a trip to a hospital could be 200-300 miles in some of Utah's rural areas). Discussion groups also noted a need for better referral systems in rural areas. They noted many referrals are not made to the closest option.
  - SUD-specific supportive services, including drug prevention programs, syringe exchanges, naloxone distribution, etc.
- *Low reimbursement and limited coverage.* Many discussion groups noted that coverage and reimbursement for supportive services is limited or non-existent. Specific areas mentioned by discussion groups that need better coverage and reimbursement include discharge planning, case management (Medicaid currently reimburses targeted case management for adults with SMI, children with SED, and individuals with SUDs),[88] peer supports, family peer support services, and therapeutic behavioral health services. "The system needs to provide coverage for the full continuum of care, just not acute care issues."

Bright Spots:

- *Utah's 1115 waiver covers housing services and supports.* Utah recently secured CMS approval for a five-year renewal of its Medicaid 1115 waiver, which will be in place through June 30, 2027. This waiver allows the state to provide housing-related supports and services to the TAM population.[89] Housing-related services and supports include tenancy support services, community transition services, and supportive living and housing services.[90] It's important to note, however, that this waiver doesn't address housing stock, affordable housing, or increasing home prices and interest rates. "We have many patients who have had housing vouchers for months and just can't find a place that is willing to take the voucher." "Having as many voices as

possible in the housing conversation is critical to getting the resources needed in communities to develop more access to affordable housing."

- *Local authorities as a model of care/system coordination.* Many local authorities have established connections or partnerships with local hospitals, schools, law enforcement, EMS, and other inpatient, outpatient, and residential mental health and substance use treatment providers that result in improved care coordination and transition support for their patients and other county residents they serve (see "Bright Spots" in the Community Education & Services section above). They also have created partnerships with community-based organizations that assist with the provision of wraparound services. Utah state statute requires Utah's local mental health authorities to provide 10 mandated mental health and SUD services to adult and children residents in their county, which includes several stabilization support and wraparound services such as case management, community supports (including in-home services, housing, family support services, and respite services), consultation and education services (including case consultation, collaboration with other county service agencies, public education, and public information), and psychosocial rehabilitation (including vocational training and skills development).

Suggested Ideas for Next Steps:

- Expansion of certified or credentialed non-licensed care team members such as certified case managers, peer support specialists, CHWs, etc. Many discussion groups voiced appreciation for the expansion of peer supports in Utah. Medicaid currently reimburses for peer supports, and a desire was expressed for private health insurance to reimburse for peer support services as well. That said, it was also noted that more provider education on how best to deploy non-licensed team members is needed to ensure they are operating to the best of their ability (i.e., not being used for non-peer-support functions).
- Develop a central coordination system with up-to-date navigation supports. Many provider network lists are currently hidden, misleading, do not include provider specialties, and do not indicate whether providers are accepting new patients. This information is important for providers who are making referrals and helping with care transitions, patients trying to determine what type of provider they need, as well as employers who are involved in helping their employees manage their behavioral health care needs. Discussion groups noted this information should be available in EDs, receiving centers, and other crisis access points.

Peer Supports

Advantages of non-licensed care team members:

- More flexibility to respond to needs and gaps in the system.
- Can help individuals with long-term depression with daily and routine tasks (a noted area with a provider shortage).
- Improve care coordination and mitigate workforce shortages.
- Help with care transitions and improve the coordination of physical and behavioral health at the patient level.

Suggested improvements to the peer support model include:

- Better reimbursement, more funding, and a sufficient wage.
- Establish a peer-support association.
- Create training opportunities that are provided by or with providers who use peer supports.
- Improve the certification process (make it shorter) and standardize training to help reduce quality differences. Some participants also noted that certification training should be peer led, and not run by clinicians.

- Improve data sharing. While behavioral health rules and regulations related to confidentiality can inhibit data sharing (and make it difficult to share data across sectors that operate under different rules and regulations such as schools), it was noted by several discussion groups that data sharing could and should improve among providers, payers, and other stakeholders within the state. Specific examples of opportunities related to improving data sharing include:
  - Expand use of the Utah Health Information Network (UHIN). UHIN access could be extended to behavioral health providers (Ohio was noted as an example state that has moved in this direction). It was also suggested that UHIN switch to an "opt out" system rather than an "opt in" system.
  - Support Utah's Child Health Advanced Records Management (CHARM) program and continued development of non-identified reports via Utah's Early Childhood Integrated Data System (ECIDS).
  - Create and utilize bed registries and other digital tools that help provide transparency, accountability, and better manage limited resources. For example, a statewide bed registry could show what beds are available at inpatient, residential, partial hospitalization, med-detox, social detox, receiving/access centers, respite, intensive outpatient, and other high-acuity level-of-care settings.
  - Establish a database or registry system that helps people accessing crisis services identify available services and be referred to appropriate systems or levels of care (for example, monitoring people moving from hospitalization to treatment to ensure appropriate follow up).
  - Develop an asset map that identifies which providers in the system have bandwidth to take on more clients, as well as potential gaps in the system.
  - Develop a data system to monitor patients moving through the continuum of care (and identify real-time gaps in the system).

BEHAVIORAL HEALTH WORKFORCE

While not formally part of Utah's continuum of behavioral health services and supports (Figure 1), Utah's ongoing, and growing, behavioral health workforce shortages are disrupting care across the continuum and a key challenge that was mentioned in most discussion groups.

Future Demand for Providers

To maintain the current 100,000 population to provider ratio over the next 10 years, it is estimated that the overall mental health workforce must increase by an average of 125.3 FTEs per year.[91] This does not include SUD providers.

Gaps, Challenges, and Needs:

- *Behavioral health providers across the care continuum.* Specific examples mentioned in different discussion groups include:
  - Licensed clinical therapists
  - Residential providers
  - Psychiatric care
  - Child and adolescent providers
  - SUD providers and prescribers
  - Providers on the west side of Utah's Wasatch Front
  - Providers that serve undocumented populations
  - Providers that serve BIPOC communities
  - Domestic violence counselors
  - Providers that treat individuals with co-occurring mental health and autism spectrum disorders
  - Providers engaged in collaborative care
  - Crisis providers (critical to 988)

Geographic Behavioral Health "Hot Spots"

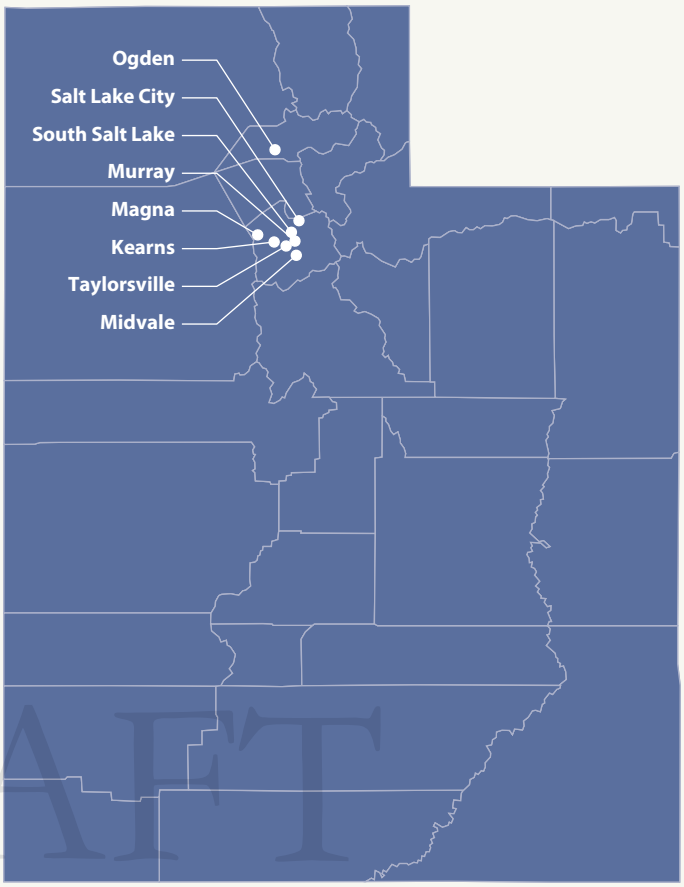
Most behavioral health data available from the Utah Department of Health and Human Services are accessible by local health district, county, or Utah Small Area. A review of these data reveal that different regions rank high on different indicators. Different indicators also measure different issues, with some indicators being more of a measure of access and others being more of a measure of need.

To understand what areas of the state may be behavioral health hot spots (or consistently rank high across different mental health indicators), the Gardner Institute compiled Utah Small Area rankings on four different measures of adult mental health: (1) diagnosed depression (2019-2021); (2) poor mental health (seven or more days or poor mental health in the past 30 days, 2019-2021); (3) suicide rates (2017-2022); and (4) four or more adverse childhood experiences (ACEs, 2016-2020).

Findings from the analysis show:

- South Salt Lake ranks in the top five Utah Small Areas on all four mental health indicators.
- Salt Lake City (Downtown) ranks in the top five on three indicators.
- Magna ranks in the top 10 for three indicators.
- Ogden (Downtown), Kearns, Midvale, Murray, and Taylorsville east/ Murray west each rank in the top 10 for two indicators.

Figure 18: Utah's Behavioral Health Hot Spots, 2020-2022



Note: Utah Small Areas that consistently rank high across select mental health indicators.
Source: Utah Department of Health and Human Services

- *Non-traditional market entrants.* Utah's workforce shortages are exacerbated by the creation of siloed and sometimes competing initiatives such as EAPs and the emergence of online mental health/counseling platforms. As noted above, some of the main concerns with these siloes are that they are not always connected back into the broader behavioral health system (limiting referrals to other services and supports patients may need, limiting the ability to support transitions within the system, and complicating patient navigation), can duplicate services in a system that is already under-resourced, and compete for providers in a system with existing workforce shortages.

Bright Spots:

- *Increased use of telehealth.* One possible positive aspect that emerged from the COVID-19 pandemic was the increased use of telehealth, telemedicine, and telepsychiatry. The Utah Legislature supported this increased use through S.B. 161 (2021), which requires coverage for mental health and SUD telehealth services. (Note: Utah's self-funded health insurance plans are not impacted by this policy.)[92] Medicare also increased the number of services that could be delivered through telehealth during the COVID-19 PHE and is starting to make some of these changes permanent.

Telehealth

The proportion of Utah's mental health providers that utilize telehealth services increased dramatically between 2016 and 2021, increasing from 7% to 60% (of survey respondents).[93]

Participants noted that increased use of telehealth has helped alleviate some workforce shortages, as well as decreased no-show rates and provided an alternative to traditional care, particularly for individuals in rural areas that have difficulty accessing providers. Maintaining reasonable rates for telehealth after the COVID-19 PHE ends will help sustain these improvements.

However, some participants feel that telehealth is not a direct substitute for in-person and crisis services. Both Medicaid and private health insurance plans have seen a recent drop in telehealth and more demand for in-person services.

Suggested Ideas for Next Steps:

- Support the creation of a Masters in Addiction Counseling degree.
- Support tuition reimbursement programs and provide student debt-reduction incentives.
- Develop more training and apprenticeship opportunities, including opportunities for students who received engagement and assessment training.
- Create pathways for upward mobility. Develop bridge and/or tuition support programs to allow non-licensed workers to train and obtain their license to advance into the clinical system.
- Continue to support growth in university-level behavioral health programs. Using appropriations allocated in the June 2020 special session, the University of Utah and Utah State University expanded their Master of Social Work programs by 70 student slots to increase the number of licensed clinical social workers (LCSWs) in Utah.
- Ensure professionals work to the top of their clinical licenses to better cultivate a workforce with a diverse number of degrees. Ensure professionals and paraprofessionals' skills are not underutilized (e.g., paraprofessionals driving vans, LCSWs working as academic counselors, peer support specialists cleaning bathrooms, etc.).
- Reduce the burden of required practicum hours, which delay licensure and discourages entrants, especially non-traditional candidates.
- Continue to implement USAAV+ behavioral health workforce recommendations.
- Develop a clear understanding of different classifications of providers and practice scopes, including doctors and nurse practitioners (i.e., prescribers), psychiatric nurses (i.e., prescribe and utilize an integrated care approach), mental health therapists, psychologists, family therapists, clinical social workers, clinical mental health counselors, licensed SUD counselors, peer supports, and case workers, among others. Identify how to maximize available staff. Broaden definitions of care provision (higher levels of education may not always be necessary). Educate legislators about different classifications and scopes as they weigh in on licensing issues.
- Develop a long-term strategic plan for enhancing the recruitment pipeline by: (1) encouraging people at a younger age to consider behavioral health (e.g., start educating sophomores in high school about the field); and (2) employing mentors that guide students to obtain grants and seek loan reimbursement related to behavioral health fields.
- Increase the compositional diversity of the workforce by: (1) assisting candidates with licensing exams, "something we see is that therapists who are non-native speakers usually fail the test 3–4 times;" (2) offering licensing exams in languages other than English; and (3) developing more inclusive testing methods.
- Expand professionals' scope of practice. For example, expand the ability of psychologists to prescribe certain medicines used in the treatment of mental disorders. Note: psychologists can prescribe in five states: Louisiana, New Mexico, Illinois, Iowa, and Idaho. In these states, psychologists are required to receive proper training and are only permitted to prescribe certain medicines used in the treatment of mental disorders.
- Improve salaries (increase public sector pay to be more comparable to private sector pay) and seek ways to reduce burnout.
- Expand the delivery of behavioral health services in primary care, such as MAT, interventions for mild-to-moderate mental health needs, and maintenance medications for individuals who are stable and no longer in need of specialty of intensive services.
- Use of peers and community health care workers to support engagement and ongoing recovery.

Appendix: Acronyms & Definitions

ACO	Accountable Care Organization. Utah Medicaid contracts with ACOs, or health plans, to provide medical services to Medicaid members. Members living in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties must choose an ACO. Members that live in any other county have the option to choose an ACO or the Fee for Service Network. Each ACO is responsible to provide enrolled Medicaid members with all medical services covered by Medicaid. Members enrolled in an ACO must receive all services through a provider on that ACO's network. The provider is paid by the ACO.[94]
AMI	Any mental illness. SAMHSA defines any mental illness as individuals having any mental, behavior, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental and substance use disorders).
ASD	Autism Spectrum Disorder
EAP	Employee Assistance Program. The U.S. Office of Personnel Management defines an EAP as "a voluntary, confidential program that helps employees (including management) work through various life challenges that may adversely affect job performance, health, and personal well-being to optimize an organization's success. EAP services include assessments, counseling, and referrals for additional services to employees with personal and/or work-related concerns, such as stress, financial issues, legal issues, family problems, office conflicts, and alcohol and substance use disorders."[95]
EPSDT	Early and Periodic Screening, Diagnostic and Treatment. The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.
HDHP	High-Deductible Health Plan
HPSA Area Definitions	Health Care Professional Shortage Areas. Mental health shortages are determined across three different domains. (1) Geographic, meaning there is a shortage of providers for the entire population within a defined geographic area. (2) Geographic High Needs, meaning at least 20% of the population has income below 100% FPL, there is a high ratio of children or elderly in the population, there is a high prevalence of alcoholism, or there is a high degree of substance use disorders. (3) Population groups, meaning there is a shortage of providers for specific population groups within a defined geographic area (e.g., low-income individuals).[96] While mental health HPSA designations can include core mental health providers in addition to psychiatrists, most mental health HPSA designations are currently based on psychiatrists only. HPSA designations based on psychiatrists only do not take into account the availability of additional mental health providers in the area, such as clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.
HSA	Health Savings Account
ID/DD	Intellectual or Developmental Disabilities
LCSW	Licensed Clinical Social Workers
Local Authorities	Utah's local authorities oversee the provision of mental health and SUD services to residents in their county. They are responsible for "providing mental health services to persons within the county; and cooperating with efforts of SUMH to promote integrated programs that address an individual's SUD, mental health, and physical health care needs."[97] In many areas they are recognized as the experts in providing behavioral health services to SMI/SED/SUD populations.
MAT	Medication Assisted Treatment
MCOT	Mobile Crisis Outreach Team
MOUD	Medication for Opioid Use Disorder
PEHP	Public Employee Health Program
PMHP	Prepaid Mental Health Plan. Most local mental health authorities (LMHAs) contract with Prepaid Mental Health Plans (PMHPs) to administer and provide mental health services. Medicaid pays PMHPs a capitated monthly fee for each Medicaid member enrolled in their plan. LMHAs may also contract with PMHPs to provide non-Medicaid covered mental health services.
Same Day Billing	Reimbursement rules that prevent providers from being reimbursed for physical and behavioral health services provided on the same day.
SBIRT	Screening, Brief Intervention and Referral to Treatment
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbances. For people under the age of 18, SAMHSA uses the term "Serious Emotional Disturbance" to refer to a diagnosable mental, behavioral, or emotional disorder, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.
SMI	Serious mental illness. SAMHSA defines serious mental illness as someone over 18 having a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.
SUD	Substance Use Disorder. SAMHSA defines substance use disorders as individuals with alcohol or illicit drug dependence or abuse.
TAM	Targeted Adult Medicaid. Utah's Targeted Adult Medicaid Program provides Medicaid services to a capped number of adults without dependent children who are: (1) chronically homeless; (2) involved in the justice system through probation, parole, or court ordered treatment needing substance abuse or mental health treatment; (3) needing substance abuse treatment or mental health treatment.
UMIC	Utah Medicaid Integrated Care program. This program integrates physical and behavioral benefits through integrated ACOs in five counties. Adult Expansion Medicaid members in Davis, Salt Lake, Utah, Washington, and Weber counties are required to enroll in a UMIC plan.

Endnotes

1. Behavioral Health Barometer Utah, Volume 6. (2020). Substance Abuse and Mental Health Services Administration. Available from https://www.samhsa.gov/data/sites/default/files/reports/rpt32861/Utah-BH-Barometer_Volume6.pdf.
2. Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 05/19/23 from www.childhealthdata.org.
3. Ibid.
4. Behavioral Health Barometer Utah, Volume 6. (2020). Substance Abuse and Mental Health Services Administration.
5. 2023-2026 Community Health Needs Assessment - University of Utah Health. (2023). University of Utah Health. Available from https://healthcare.utah.edu/documents/community-health-needs-assessment-report-2023-2026v2.
6. Ipsos Global Health Service Monitor 2020: A Global Advisor Survey. (2022 September). Ipsos. Available from https://www.ipsos.com/sites/default/files/ct/news/documents/2022-09/Ipsos-global-health-service-monitor-2022_0.pdf.
7. Utah's Mental Health Workforce, 2021. (2021 November). Utah Medical Education Council. Available from umec-shiny-prod-alb-79075571.us-west-2.elb.amazonaws.com/projects/Mental_Health/.
8. Ibid.
9. Highlights for the 2021 National Survey on Drug Use and Health. (2023 January). 2021 National Survey of Drug Use and Health (NSDUH) Release. Substance Abuse and Mental Health Services Administration. Available from https://www.samhsa.gov/data/release/2021-national-survey-drug-use-and-health-nsduh-releases.
10. Summers, L., Meppen, D., Ball, S. (2019 August). Utah's Mental Health System. Kem C. Gardner Policy Institute, The University of Utah David Eccles School of Business.
11. Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., Kessler, R.C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. Archives of General Psychiatry. 62:629–640.
12. Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K.R., et al. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R) Journal of the American Medical Association. 289:3095–3105.
13. Kessler, R.C., Heeringa, S., Lakoma, M.D., Petukhova, M., Rupp, A.E., Schoenbaum, M., Wang, P.S., Zaslavsky, A.M. (2008). Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication. American Journal of Psychiatry. 165(6):703-11. Leopold, R.S. (2001). A Year in the Life of a Million American Workers. New York, New York: MetLife Disability Group. Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R., Morganstein, D. (2003). Cost of Lost Productive Work Time among U.S. Workers with Depression. JAMA. 289(23):3135-3144.
14. GBD 2015 Disease and Injury Incidence and Prevalence Collaborators Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990–2015: A systematic analysis for the Global Burden of Disease Study 2015. (2015). Lancet. 388:1545–1602.
15. Eisenberg, D., and Neighbors, K. (2007). Economics of Preventing Mental Disorders and Substance Abuse Among Young People. Paper commissioned by the Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions, Board on Children, Youth, and Families, National Research Council and Institute of Medicine, Washington, DC.
16. Livingston, S. (2020 August). Behavioral health patients spur 57% of commercial healthcare spending. Modern Healthcare.
17. Davenport, S., Gray, T.J., Melek, S. (2020 August). How do individuals with behavioral health conditions contribute to physical and total healthcare spending? Milliman Research Report. Available from https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx.
18. Bellon, J., Quinlan, C., Taylor, B., Nemecek, D., Borden, E., Needs, P. (2022). Association of Outpatient Behavioral Health Treatment with Medical and Pharmacy Costs in the First 27 Months Following a New Behavioral Health Diagnosis in the US. JAMA Network Open. 5(12):e2244644.
19. Lohr, K.N., editor. (1990). Medicare: A strategy for quality assurance. IOM (Institute of Medicine). Washington, DC: National Academy Press.
20. For more information see "SURE: Substance Use Recovery Evaluator." Available from https://www.kcl.ac.uk/research/sure-substance-use-recovery-evaluator.
21. For more information see Intermountain Primary Children's Hospital "Talk to Tweens." Available from https://intermountainhealthcare.org/primary-childrens/wellness-prevention/emotional-wellbeing.
22. Melek, S., Norris, D., Paulus, J. (2014 April). Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Milliman, Inc. Soper, M., (2016 April). Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators. Center for Health Care Strategies.
23. Herbert, G. (2018). Budget Recommendations Fiscal Year 2020, Fiscal Year 2019 Supplements. The State of Utah.
24. People Dually Eligible for Medicare and Medicaid. (2019 March). Fact Sheet. Medicare-Medicaid Coordination Office. Centers for Medicare & Medicaid Services.
25. Donaldson, M.S., Jordy, K.D., Lohr, K.N., et al., editors. (1996). Primary Care: America's Health in a New Era. Institute of Medicine (U.S.) Committee on the Future of Primary Care. Washington (DC): National Academies Press (U.S.)
26. Utah Drug Monitoring Initiative Annual Report Analysis of the impact related to illicit drug use in Utah – 2020/2021. Utah Department of Health and Human Services.
27. Utah Health Status Update. (2022 December). Utah Department of Health and Human Services. Available from https://ibis.health.utah.gov/ibisph-view/pdf/opha/publication/hsu/2022/12_DrugAlco_VIPP.pdf#Spotlight.
28. Hollingshaus, M., Hogue, M., Harris, E., et al. (2022 January). Utah Long-Term Planning Projections: A Baseline Scenario of Population and Employment Change in Utah and its Counties. Kem C. Gardner Policy Institute, The University of Utah David Eccles School of Business.
29. For more information and examples see the National Council for Mental Wellbeing "Center of Excellence for Integrated Health Solutions." Available from https://www.thenationalcouncil.org/program/center-of-excellence/resources/.
30. Summers, L., Meppen, D., Ball, S. (2019 August). Utah's Mental Health System. Kem C. Gardner Policy Institute, The University of Utah David Eccles School of Business.
31. Subsection 26B-5-104 of Utah Code identifies the responsibilities of the OSUMH and 17-43-201 and 17-43-301 outlines the responsibilities of the county local substance abuse authorities and local mental health authorities. When current statutory responsibilities were identified, the county system was solely responsible for publicly funded behavioral health services. Since then, the state of Utah has developed several other service delivery systems (Targeted Adult Medicaid, Medicaid Expansion, Services for Kids in Custody) that are managed and implemented outside of OSUMH and the county system.
32. H.B. 413 (2022) requires the Department of Health and Human Services (DHHS) to convene a working group to discuss the delivery of Medicaid behavioral health services. S.B. 41 (2022) requires DHHS to award a grant to a local mental health authority to implement or expand an integrated behavioral health program.
33. Landi, H. (2021 April 21). The digital mental health market is booming. Here's why some experts are concerned. Fierce Healthcare. Available from https://www.fiercehealthcare.com/tech/digital-mental-health-market-booming-here-s-why-some-experts-are-concerned.
34. Hawley, J. (2022 December). 2022 Utah Health Insurance Market Report. Utah Insurance Department. Available from https://insurance.utah.gov/wp-content/uploads/2022HealthMarketReport.pdf.
35. 26 CFR 601.602: Tax forms and instructions. IRS Rev. Proc. 2022-24.
36. Dixon, A., Greene, J., & Hibbard, J. (2008). Do consumer-directed health plans drive change in enrollees' health care behavior? Health Affairs. 27(4):1120-31.

37. 2016 data. Kaiser Family Foundation analysis of National Health Interview Survey. Cox, C., Sawyer, B. (2018 January 17). How Does Cost Affect Access to Care? Preston-Kaiser Healthy System Tracker.
38. FindSupport.gov was opened in 2023. The website provides information on how to get support for mental health, drug, and alcohol issues; what common questions to ask the start of a behavioral health journey; how to find a health care professional or program that meets individual needs; and tools to ask better questions of health care professionals to feel confident going into treatment. The website complements findtreatment.gov, which helps people locate treatment facilities or providers.
39. Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223. IRS Notice 2019-45.
40. Crisis respite homes often exist in residential settings and provide short-term crisis services. Each home serves a small number of individuals who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions. Placement in crisis respite homes most commonly occurs when individuals have not responded to less restrictive crisis interventions.
41. Recovery and Recovery Support. "The Four Major Dimensions of Recovery." Substance Abuse and Mental Health Services Administration. Available from https://www.samhsa.gov/find-help/recovery.
42. USAAV+ comprises representatives from Utah State courts, law enforcement, Adult Probation and Parole Utah Department of Public Safety, Division of Multicultural Affairs, Utah State Courts including mental health and other therapeutic courts, Division of Juvenile Justice Services, healthcare and hospital systems, statewide substance use disorder and mental advocacy groups advocates, Utah League of Cities and Towns, Utah Department of Health and Human Services, Utah Attorney General, Statewide Association of Prosecutors, local law enforcement agencies, county health departments, county mental health and substance use disorder agencies, Commission for Criminal and Juvenile Justice, Utah Department of Corrections, Utah Department of Veterans and Military Affairs, Utah defense bar, Salt Lake Legal Defender Association, person affected by mental health/substance use disorder, University of Utah Medical School, various care and recovery providers for both adult and youth, Utah State Board of Education, addiction treatment providers, and Utah Division of Child and Family Services.
43. For more information see "Utah's Health Workforce Advisory Council." Available from https://ruralhealth.health.utah.gov/health-workforce-advisory-council/.
44. For more information see "Utah AHEC (Area Health Education Centers)." Available from https://utahahec.org/.
45. For more information see "Utah's Mental Health System." Available from https://gardner.utah.edu/wp-content/uploads/MentalHealthReportAug2019.pdf.
46. For more information see "Early Childhood Mental Health in Utah." Available from https://gardner.utah.edu/wp-content/uploads/Child-Ment-Health-Dec2020.pdf?x71849.
47. For more information see "Moving Toward Evidence-Based Programs: Medication-Assisted Treatment for Opioid Use Disorder in Utah." Available from https://gardner.utah.edu/wp-content/uploads/MATinUtah-Pew-04132020.pdf?x71849.
48. For more information see "A Roadmap for Improving Utah's Behavioral Health System." Available from https://gardner.utah.edu/wp-content/uploads/UHA-Behavioral-Health-Feb2020.pdf?x71849.
49. For more information see "A Roadmap for Improving Utah's Behavioral Health System: 2021 End-of-Year Update." Available from https://gardner.utah.edu/wp-content/uploads/DSAMH_UHA-BehavioralHealth-Dec2021-Final.pdf?x71849.
50. For more information see "A Pathway for Improving Early Childhood Mental Health in Utah." Available from https://gardner.utah.edu/wp-content/uploads/ChildMentHealth-Apr2022.pdf?x71849.
51. Mental Health Facts: Children and Teens. NAMI. Available from http://namimd.org/uploaded_files/475/Children-MH-Facts-NAMI.pdf.
52. For more information see "Utah Opioid Crisis Response Blueprint: A Roadmap for Opioid Settlement Investments: County, Municipality, and Statewide Stakeholders" (March 1, 2022 Version). Available from https://attorneygeneral.utah.gov/wp-content/uploads/2022/05/Utah-Opioid-Settlement-Blueprint-Release-3_1_22-1-1.pdf.
53. For more information see "Blueprints for Healthy Youth Development." Available from https://www.blueprintsprograms.org/.
54. For more information see "Live On." Available from https://liveonutah.org/.
55. For more information see "Campaign Partners," Live On. Available from https://liveonutah.org/partners/.
56. Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services. Population Estimates: National Center for Health Statistics (NCHS) through a collaborative agreement with the U.S. Census Bureau, IBIS Version 2019. National Center for Injury Prevention and Control's Web-based Injury Statistics Query and Reporting System (WISQARS).
57. Ibid.
58. Ibid.
59. Kim, B. (2022 October 18). Utah Governor Focused on Addressing Social Media's Harms to Youth Mental Health. State of Reform.
60. Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory. (2023). U.S. Department of Health and Human Services. Available from https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf.
61. Whitney, D., Peterson, M. (2019 February). U.S. National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatrics.
62. For more information see "JED Campus." Available from https://www.jedcampus.org/.
63. University of Utah Communications. (2020 January 24). Improving Mental Health Support for Students. The University of Utah.
64. Behavioral Health Barometer Utah, Volume 6. (2020). Substance Abuse and Mental Health Services Administration.
65. Removal of DATA Waiver (X-Waiver) Requirement. Substance Abuse and Mental Health Services Administration. Available from https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement.
66. Shatzkes, K., Scott, K. (2021 November 8). Expanding Access to Treatment For Opioid Use Disorder: Beyond "X-ing The X-Waiver." Health Affairs Forefront.
67. Utah Rural Veteran Needs Assessment. (2022 April 25). Utah Department of Health.
68. Vanneman, M.E., Rosen, A.K., Wagner, T.H., Shwartz, M., Gordon, S.H., Greenberg, G., Zheng, T., Cook, J., Beilstein-Wedel, E., Greene, T., Kelley, A.T. (2022). Differences Between VHA-Delivered and VHA-Purchased Behavioral Health Care in Service and Patient Characteristics. Psychiatric Services. 74(2).
69. H.R. 5218, 117th Congress (2021-2022).
70. Collaborative Care. AIMS Center (Advancing Integrated Mental Health Solutions), University of Washington, Psychiatry & Behavioral Sciences, Division of Population Health. Available from https://aims.uw.edu/collaborative-care.
71. For more information see "CALL-UP Psychiatry Consult Service." Available from https://healthcare.utah.edu/hmhi/programs/call-up.
72. Utah's Mental Health Workforce, 2021. (2021 November). Utah Medical Education Council.
73. Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., Kessler, R.C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. Archives of General Psychiatry. 62:629–640.
74. Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K.R., et al. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R) Journal of the American Medical Association. 289:3095–3105.
75. Gitlin, L.N. (2013). Introducing a new intervention: an overview of research phases and common challenges. American Journal of Occupational Therapy. 67(2):177-84.
76. Adams, H.L., Matson, J.L. (2015). Scope and Prevalence of the Problem. In J. L. Matson & M. L. Matson (Eds.), Comorbid Conditions in Individuals with Intellectual Disabilities. Springer International Publishing.
77. Disabilities in Utah. Utah Department of Health and Human Services. Available from https://health.utah.gov/disabilities#:~:text=A%20new%20report%20shows%20one,are%20living%20with%20a%20disability.
78. S.B. 95: Autism Amendments (2019 General Session).
79. For more information see "Treatment Resource Centers," Utah Department of Corrections. Available from https://corrections.utah.gov/probation-parole/treatment-resource-centers/.

80. For more information see "Criminal Justice Reform in Utah," Utah Commission on Criminal & Juvenile Justice. Available from https://justice.utah.gov/about-ccjj/justice-reinvestment-initiative/.
81. For more information see State of Utah Section 1115 Demonstration Amendment "Medicaid Coverage for Justice-Involved Populations." Available from https://medicaid.utah.gov/Documents/pdfs/1115%20Waiver%20Amendment-%20MedicaidJusticeInvolved-PublicCommentDraftCombined.pdf.
82. Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey 2021 1-Year Estimates.
83. The Sequential Intercept Model (SIM). Substance Abuse and Mental Health Services Administration. Available from https://www.samhsa.gov/criminal-juvenile-justice/sim-overview.
84. For more information see "Crisis Intervention Team Utah." Available from https://cit-utah.com/.
85. Substance Use Disorder (SUD) Treatment. Utah Department of Health and Human Services. Available from https://medicaid.utah.gov/substance-use-disorder-sud-treatment/.
86. State of Utah. (2021). Managed Care Quality Strategy. Division of Medicaid and Health Financing, Bureau of Managed Health Care. Available from https://medicaid.utah.gov/Documents/pdfs/Utah%20Managed%20Care%20Quality%20Strategy%202021.pdf.
87. Out-of-Home Services. "Crisis Respite Homes." Georgia Department of Behavioral Health and Developmental Disabilities. Available from https://dbhdd.georgia.gov/be-dbhdd/be-compassionate/out-home-services.
88. Targeted Case Management for Individuals with Serious Mental Illness. Utah Department of Health and Human Services. Available from https://medicaid-manuals.dhhs.utah.gov/TCM_Serious_Mental_Illness/tcm_serious_mental_illness.htm.
89. Individuals with acute and chronic medical and behavioral health conditions, criminal justice system involvement, and extended periods of unemployment and poverty who are experiencing homelessness, housing, food or transportation insecurity, interpersonal violence, or trauma.
90. For more information on available services see CMS approval of Utah's "Medicaid Reform 1115 Demonstration." (2022 June 30). Available from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-pcn-appvl-06302022.pdf.
91. Utah's Mental Health Workforce, 2021. (2021 November). Utah Medical Education Council.
92. The telehealth platform used must be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to be reimbursed. The Legislature also passed S.B. 41 (2021), which was superseded by S.B. 161 (2021), and H.B. 313 (2020), which requires comprehensive health insurance plans to provide coverage and reimburse contracted providers for telehealth services and telemedicine services at a commercially reasonable rate.
93. Utah's Mental Health Workforce, 2021. (2021 November). Utah Medical Education Council.
94. Accountable Care Organizations. Utah Department of Health and Human Services. Available from https://medicaid.utah.gov/accountable-care-organizations/.
95. Employee Assistance Programs. U.S. Office of Personnel Management. Available from https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/#:~:text=An%20EAP%20is%20a%20voluntary,to%20optimize%20an%20organization's%20success.
96. Health Professional Shortage Areas (HPSAs). (2016 October). Health Resources & Services Administration. Ryan, M. (2017 May). Key Principles of Shortage Designation. Centene Corporation.
97. U.C.A. §17-43-301 and U.C.A. § 62A-15-103. Utah State Legislature.

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