Utah Hospital Association

Utah Department of Human Services, Division of Substance Abuse and Mental Health

A Roadmap for Improving Utah's Behavioral Health System

2021 End-of-Year Update

Version 2.0 | December 2021

Contents

Note about the Utah Department of Health and Department of Human Services Consolidation

The State of Utah is currently in the process of consolidating the Utah Department of Health and Department of Human Services. The consolidation process is ongoing and many of the details, such as restructuring specific divisions and responsibilities within and across the departments, are yet to be determined.

As such, it is important to note that these plans and the entities that are currently overseeing the development and implementation of these recommendations may change.

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

UHA
UTAH HOSPITAL ASSOCIATION

Improving Utah's behavioral health system requires an organized, comprehensive, and coordinated approach that eliminates existing gaps and enhances current services across the full continuum of behavioral health care. It also requires taking initial steps to system improvement while continually evaluating the impacts of these steps in the context of an evolving behavioral health system.

The Utah Hospital Association (UHA) released *A Roadmap for Improving Utah's Behavioral Health System* in February 2020. 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 is to provide a guide 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.

A tremendous amount of work has been done over the past two years to improve Utah's behavioral health system. However, this work is ongoing and more work is needed in many areas moving forward. While these areas will be addressed in the master plan for improving Utah's behavioral health system (to be developed over the next year), the following areas may benefit from more immediate action.

1. **Continue to support and fund Utah's behavioral health crisis system.**
2. **Improve the continuum of services and supports for individuals with high-acuity behavioral health needs.**
3. **Better integrate substance use disorders into the full continuum of behavioral health services and supports.**
4. **Address Utah's behavioral health workforce challenges.**
5. **Address Utah's commitment laws.**

Future Phases

The Roadmap released in February 2020 included an initial set of recommendations that primarily focused on mental health. UHA acknowledges in the report that these recommendations represent initial steps to system improvement, but that future phases and a broader set of recommendations are needed to ensure continual system improvement of Utah's larger behavioral health system.

UHA is currently working with the Utah Department of Human Services, Division of Substance Abuse & Mental Health (DSAMH), the Utah Substance Use Advisory and Mental Health Advisory Council (USAAV+), major health systems in the state, and other stakeholders from Utah's behavioral health community to develop a master plan for improving Utah's behavioral health system. The master plan will extend beyond mental health to include recommendations that address aspects of Utah's entire behavioral health system, including substance use disorder (SUD) services, law enforcement, children's services, services for historically underserved communities, and homeless services, among other areas. Work on the master plan is expected to begin at the end of 2021.

UHA also acknowledges that improvement comes from continually evaluating the impacts of these initial—and future—recommendations in the context of an evolving behavioral health system. As part of this evaluation, and in preparation for the master plan, UHA worked closely with DSAMH to provide an update on the recommendations included in the 2020 Roadmap, highlight remaining gaps and some preliminary recommendations that address immediate needs within the system. These preliminary recommendations will continue to be refined and evaluated in context of the broader master plan.

Update on Original Recommendations

This report provides a high-level update on the recommendations included in the 2020 Roadmap report, identifies areas where more work is being done, and highlights remaining gaps in the system or where more work is needed. It references some of the supporting legislation that has been passed in the last few years to improve Utah's mental health system, building on a progress report developed by the Office of Legislative Research and General Council in April 2021.[1] This legislation underscores the commitment from Utah's legislative champions to pass thoughtful, evidence-based, and system-building legislation. It also details some of the work done by divisions within the Utah Department of Human Services (DHS) and the Utah Department of Health (UDOH), as well as other state agencies and public, private, and nonprofit health systems in the state.

Research Notes

- It is important to note that the updates provided in this report are not comprehensive of all the work done over the past two years as many health systems, providers, councils, coalitions, and other stakeholders have been working towards improving Utah's behavioral health system.
- As noted in the 2020 Roadmap report, this update includes only summary details on each recommendation. For more information, please contact UHA or DSAMH.
- Finally, as noted above, the 2020 Roadmap primarily focused on mental health. Many of the updates detailed below focus on the broader issue of behavioral health, which includes both mental health and SUDs. In both the original roadmap and in this update, the term "behavioral health" is used to describe both mental health conditions and SUDs, unless otherwise specified. When mental health conditions or SUDs are referred to separately, the term "mental health" or "SUD" is used.

Section 1: Preliminary Recommendations

Section 2 reveals that a tremendous amount of work has been done over the past two years to improve Utah's behavioral health system. The information also reveals that this work is ongoing and that more work is needed in many areas moving forward. While these areas will be addressed in the master plan for improving Utah's behavioral health system, the areas noted below may benefit from more immediate action.

1. **Continue to support and fund Utah's behavioral health crisis system**.

   In preparation for the federal rollout of 988 as a nationwide 3-digit number for mental health crisis and suicide prevention services, it is imperative for the State to continue to fully support and fund its behavioral health crisis system. The behavioral health crisis system serves individuals with mental health and/or SUD needs and comprises Utah's:

   a. Statewide crisis call center (includes the statewide crisis and warm lines and serves as the centralized hub for coordinating behavioral health and crisis support services).
   b. Mobile Crisis Outreach Teams (MCOTs).
   c. Newly developed (and to-be-developed) community-based behavioral health receiving centers (located in Davis, Salt Lake, Utah, and Washington counties).
   d. Services and supports within the range of subacute care, including withdrawal management and detox services, partial hospitalization and other intensive outpatient services, and subactute hospital care. Note: 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.
   e. Acute inpatient care system (comprises the Utah State Hospital and other behavioral health inpatient hospital facilities).

2. Improve the continuum of services and supports for individuals with high-acuity behavioral health needs.

A key component of fully supporting and funding Utah's behavioral health system is making improvements to services and supports for individuals with high-acuity behavioral health needs (including residential care, transitional housing, detox and other sober living and residential addiction recovery programs, etc.). As noted in Section 2, this is an area that needs more focus on moving forward. For example, more needs to be done to evaluate:

a. How best to support individuals with high-acuity behavioral health needs in Utah (individuals diagnosed with serious mental illness (SMI) or SUDs who need significant treatments, services, and supports and often intersect with other state systems, such as the justice system, hospital systems, and housing systems).
b. The most pressing high-acuity behavioral health needs within Utah's behavioral health system and what care settings are required to address those needs.
c. How best to stimulate growth of high-acuity behavioral health services outside of Salt Lake County (limited options currently exist in rural Utah, despite the growing need for these services).
d. The role of local government in delivering these services and what resources are needed to provide high-touch, effective care for this population.
e. How best to provide or coordinate with other entities (e.g., Utah's housing authorities, associations of governments, or nonprofit entities) to develop supportive housing for individuals with behavioral health needs who experience, or are close to experiencing homelessness.

3. Better integrate SUDs into the full continuum of behavioral health services and supports.

More needs to be done to evaluate how best to integrate SUD into the full continuum of behavioral health services and supports (Figure 1). Given short windows of opportunity that exist in key moments to engage individuals with SUDs in medication-assisted treatment and other addiction treatment programs, it is imperative to leverage existing mental health and primary care services, supports, and referrals to better promote no-wrong-door access to SUD treatment.

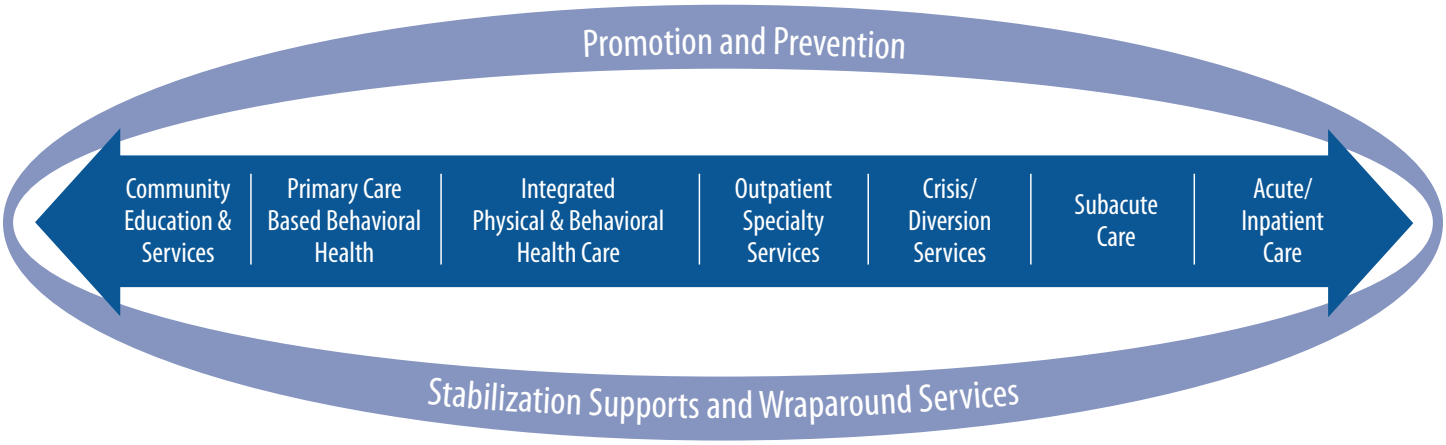
4. Address Utah's behavioral health workforce challenges.

Utah has long experienced behavioral health workforce shortages that have been exacerbated by provider burnout during COVID-19, rapid population growth, and increasing serious behavioral health needs. As noted in Section 2, studying effective ways to address Utah's behavioral health workforce shortages will be a key component of the master plan for improving Utah's behavioral health system.

That said, it is imperative that the State continue to work on addressing immediate challenges within Utah's behavioral health workforce while the master plan is developed. Examples include:

a. Addressing critical staffing needs at the Utah State Hospital and other care facilities that provide services to individuals with high-acuity behavioral health needs.
b. Determining whether the reimbursement rates for behavioral health providers and services in Utah need to increase to support and maintain an adequate workforce, particularly given the retention challenges that worsened during COVID-19 as well as the fact that multiple entities (schools, clinics, health systems, etc.) now compete for the same limited workforce.

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



c. Evaluate what changes can or should be made to level the regulatory, licensing, and reporting requirements for behavioral health providers across Utah's public and private systems. This could help increase workforce retention and ensure systems with fewer requirements better align with national standards. Some of this work is currently being evaluated as part of the State's consolidation of UDOH and DHS.

5. Address Utah's commitment laws.

According to an analysis of U.S. psychiatric treatment laws, Utah ranks in the lower half of states in terms of its laws governing involuntary treatment for psychiatric illness. Involuntary treatment generally comprises:

a. Emergency psychiatric evaluation: "When an individual believed to be in psychiatric crisis refuses to undergo a clinical evaluation, it is sometimes necessary, as authorized by statute, to remove the individual from the community and place them under a short-term emergency hold so that an evaluation may be performed."

b. Inpatient commitment: Supporting laws "empower a court to order a person with mental illness to be held over their objection for a period of care and treatment."

c. Outpatient commitment: Supporting laws "motivate the individual to regard treatment adherence as a legal obligation and impress upon treatment providers that the individual requires close monitoring and comprehensive services."[2]

Utah's low grade and ranking is primarily due to the short length of Utah's emergency psychiatric hold, found in 62A-15-629 (3), and the lack of quality criteria defining psychiatric deterioration.

To better protect and support individuals experiencing behavioral health crises, 2022 General Session legislation is being considered that would strengthen these areas of Utah's commitment laws.

Section 2: Update on Recommendations included in the 2020 Roadmap

Tier I: Immediate actions to address acute care needs

#	Recommendation	Status
Promotion and Prevention		
1	**Continue to increase the number of health care systems participating in Zero Suicide.** A list of Utah health systems and organizations participating in the Zero Suicide initiative is included in the Appendix.	HB 336 (2021) allocated $350,000 for training health care organizations on suicide prevention. This funding provided DSAMH with additional opportunities to support the growing number of participating health systems in the Zero Suicide initiative with both funding and technical support. Currently, most of the major health systems in the state of Utah are participating in the Zero Suicide initiative, including the state's local mental health and substance abuse authorities. DSAMH will continue to assist Utah's health systems adopt and fully integrate the Zero Suicide framework into their systems through ongoing technical support and staff training.
2	**Continue public/private commitment to behavioral health-focused public education campaigns.** An example of this public/private commitment is the state suicide prevention campaign, which is a three-year media campaign supported by $2 million in public and private funding. Future campaigns should consider highlighting when, where, and how to access the behavioral health system based on severity of need, and link Utahns to robust prevention and awareness websites.	The State of Utah continues to support behavioral health–focused public education campaigns, including "Know Your Script," "Parents Empowered," and "Live On." The Live On campaign was initially supported by HB 393 (2019), which provided $700,000 to the Governor's Suicide Prevention Fund and was matched by private donations. HB 32 (2020) provided an additional $100,000 in ongoing funding to the Governor's Suicide Prevention Fund, but this fund supports other initiatives as well. The Live On campaign is currently funded with state funds and private donations. Additional funding will be needed to maintain this campaign over time. HB 337 (2021) provided $500,000 to be used for a public education campaign for early childhood mental health intervention.

#	Recommendation	Status
Stabilization Supports and Wraparound Services		
3	**Increase reimbursement and use of certified peers, case managers, and community health workers (i.e., non-traditional health workers and teams) across the behavioral health system and in integrated care settings.**	The State of Utah increased Medicaid reimbursement rates for certified peer support specialists and case management services in SFY2019, SFY2020, and SFY2021. UDOH and DSAMH are currently evaluating policies to support statewide community health worker (CHW) certification. Once the certification process is in place, the Division of Medicaid and Health Financing can take steps toward establishing CHWs as a Medicaid-certified provider type and then work with UDOH/DHS to establish a Medicaid reimbursement rate. The State, several health systems, community-based organizations, and other entities in Utah utilize CHWs and/or are engaged in initiatives to increase the use of CHWs in Utah. For example, Governor Cox's One Utah Roadmap includes an action item to "Hire and train more community health workers."[3] The State of Utah employed CHWs to assist with the COVID-19 response and connect individuals with resources using COVID-19 relief funds. These CHWs are embedded in local health departments for the next couple of years. Moving forward, the reimbursement rates provided to certified peer support specialists and case managers need to be evaluated as part of a larger initiative to determine whether the reimbursement rates for behavioral health providers in Utah are sufficient to support and maintain an adequate workforce, particularly given the retention challenges that worsened during COVID-19.
4	**Establish a digital referral platform.** The digital referral platform will help coordinate referrals to community health centers, local mental health authorities, and other organizations that provide behavioral health-focused stabilization supports and other social services that address "whole-person" care needs.	The development of a digital referral platform has been the focus of Governor Cox's One Utah Roadmap Social Determinants of Health (SDOH) Committee in response to the action item to "Identify and invest in priority services and infrastructure needs that impact SDOH."3 A more recently updated version of the Roadmap, which was reviewed after 250 days, was made available on October 20, 2021 and reiterates a focus on identifying and investing in IT infrastructure needs that improve social determinants of health service delivery.[4] Several of Utah's state agencies and health systems are also engaged in operating or developing digital referral platforms. For example, DSAMH continues to improve and expand the digital platform it uses for the Utah Crisis Line and mobile crisis outreach team deployment. The State's updated electronic health record (EHR) system also allows for better communication and billing across Utah's behavioral health crisis system, and the State is in the early stages of developing a bed registry to better identify openings at mental health and SUD facilities. The Utah Alliance for the Determinants of Health, a community collaborative convened by Intermountain Healthcare, is using the Unite Us technology platform to connect people in need with health care and social service providers.[5] There also needs to be a stronger focus on developing and expanding platforms that connect individuals to behavioral health treatment, recovery supports, and other social service and support providers. As these different referral systems develop, UHA, DHS, and other key stakeholders need to maintain continued communication and collaboration to ensure coordination and interoperability across the systems where appropriate. This will be a key focus during the UDOH/DHS consolidation, as one of the goals for the new Utah Department of Health and Human Services is to better connect public and private service providers to resources and services that support people experiencing health challenges.

#	Recommendation	Status
Community Education & Services		
5	**Continue to increase early intervention by increasing access to and use of the SafeUT app and school-based mental health (with referral supports).**	**Expand access to SafeUT:** HB 32 (2020) included $250,000 in ongoing funding to expand SafeUT to health care workers, firefighters, law enforcement, first responders, and dispatchers (SafeUT Frontline). SafeUT also expanded to National Guard members in 2019 (SafeUTNG). The State is continuing to work with the Utah System of Higher Education (USHE), with support from a Marriott Foundation grant, to expand SafeUT to Utah's higher education systems. The app is currently being promoted and used by all public higher education institutions and technical colleges across Utah. Westminster College, one of the state's private institutions, is also enrolled in SafeUT. **Expand access to school-based mental health services:** Expanding access to school-based mental health services to students in need was a key focus of the Utah Legislature in 2019, 2020 and 2021. Examples include: • HB 373 (2019) provided $16 million in funding for school FY2020–21, and $26 million in ongoing funding after school FY2020–21, to support SafeUT and School Safety Commissions, student health and mental health counseling, and other health and mental health services. • HB 323 (2020) requires the use of age-appropriate mental health/suicide screeners in schools. • HB 93 (2021) clarifies provisions related to youth suicide programs. • HB 288 (2021) created the Education and Mental Health Coordinating Council that will develop recommendations regarding behavioral health supports provided to youth and families within the state. In addition to the examples of legislative support listed above, DSAMH is currently working with the Utah State Board of Education (USBE), Local Education Agencies (LEAs), and Local Mental Health Authorities (LMHAs) on several initiatives to expand access to school-based behavioral health services to students in need. Examples include, but are not limited to: • Increasing coordination between LEAs and LMHAs. According to Utah's 10th annual report on intergenerational poverty, access and availability to school-based behavioral health increased to 39 of Utah's 41 school districts in SFY2020. As part of this expansion, Utah's LMHAs provided school-based behavioral health services to 3,265 students.[6] • DSAMH leveraged state and local funds to develop and place 172 telehealth kits in Utah's rural and Title I schools. It is currently evaluating how to expand distribution of these kits to more Utah schools. • These initiatives align with and support the One Utah Roadmap's (Version 1) action item to "Increase efforts to provide access to mental and physical health personnel in every school." DSAMH is also assessing access to and availability of behavioral health services in Utah's K–12 schools in order to identify gaps in services and better coordinate referral support, particularly in areas of high need.

#	Recommendation	Status
Primary Care–Based Mental Health		
6	**Support the launch of the University of Utah's Child and Adolescent Mental Health certificate program.** University of Utah pediatric psychiatry and behavioral health faculty are developing a Child and Adolescent Mental Health distance-learning certificate program for primary care physicians, nurse practitioners, and physician assistants. Through this program, providers will access empirically-based, best practice content related to assessment, diagnosis, and treatment of psychiatric disorders in primary care settings. The goal of the program is to allow youth to receive care as close to home as possible from the providers they already trust.	HB 246 (2020) provided $600,000 to support the launch of the University of Utah's Child and Adolescent Mental Health certificate program (contingent on the support of matching funds). However, the launch of this program was delayed due to COVID-19 and other competing priorities. The University of Utah is currently exploring the launch of the program and possible funding sources.

#	Recommendation	Status
Integrated Physical & Mental Health Care		
7	**Increase the use of integrated care models that support Collaborative Care codes.** Collaborative Care is a type of integrated care model that treats common mental health conditions such as depression and anxiety. Trained primary care providers and embedded behavioral health professionals provide medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving.[7] Based on the principles of effective chronic illness care, collaborative care uses evidence-based treatment and tracks patient populations in a patient registry. It is estimated that 90% of Utahns have health insurance plans that reimburse for Collaborative Care codes, including Medicaid.	The Utah Medicaid program, Medicare, TRICARE, PEHP, and several major commercial health insurance plans in the state of Utah currently reimburse 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, including in its community clinics. UHA recommends more work be done to educate and support other health systems and providers in Utah to implement the Collaborative Care model. The model promotes integrated care and supports the treatment of mild-to-moderate mental health conditions (such as depression and anxiety) in a primary care physician's office, supports suicide prevention efforts through increased screenings and awareness, and can help address workforce challenges by expanding psychiatrists' reach to more patients and allowing them more time to practice at the top of their license. The State of Utah could also consider supporting use of the Collaborative Care model by giving preference to Utah Medicaid Accountable Care Organizations (ACOs) or Medicaid-enrolled providers that use Collaborative Care codes (e.g., through an enhanced rate, quality initiative, or other pay-for-performance mechanism).

#	Recommendation	Status
Crisis/Diversion Services		
8	**Enhance the statewide crisis call center to serve as the centralized hub for coordinating behavioral health and crisis support services.** The enhanced call center would serve as a 911 for behavioral health. It will include a triage process to get people to the right care, at the right time, by being connected to a comprehensive system of care.	HB 32 (2020) created a statewide warm line for individuals who need mental health support, but are not experiencing a crisis (and provided funding for the statewide crisis and warm lines).[8] SB 155 (2021) created the Statewide Behavioral Health Crisis Response Account, which provides ongoing funding to the statewide crisis and warm lines.[9] In addition to supporting the crisis and warm lines, DSAMH has been working with the federal government on the designation and local establishment of 988 as a nationwide 3-digit number for mental health crisis and suicide prevention services. SB 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 Utah Crisis Response Commission. The Utah Crisis Response Commission has produced a detailed report of service and financing needs for the establishment of the 988 number, which will be submitted to the Utah Legislature in December 2021.
9	**Extend 24/7 mobile crisis outreach teams (MCOT) across the entire state.** MCOTs relieve law enforcement from being the caregiver of first or last resort in behavioral health emergencies. They divert people from costly emergency room (ER) or inpatient care when not indicated, divert people from ineffective jail admissions for psychiatric disturbances that are not a threat to public safety, and work closely with other rural area stabilization teams.	Legislation passed in 2020 and 2021 provided funding to extend Utah's MCOTs across the entire state: • HB 32 (2020) provided $275,000 in one-time and ongoing funding for additional MCOTs in Utah's rural areas. • SB 155 (2021) created the Statewide Behavioral Health Crisis Response Account, which provides funding to Utah's MCOTs. • SB 47 (2021) created the mental health crisis intervention council, which establishes protocols and standards for the training and functioning of local mental health crisis intervention teams. As of August 2021, all counties in the state of Utah have active MCOTs. DSAMH is continuing to explore the expansion of MCOTs to ensure there is sufficient capacity to meet ongoing and growing community needs.
10	**Create three community-based behavioral health receiving centers.** Specializing in rapid assessment, evaluation, and stabilization, these centers will accept behavioral health walk-ins, referrals, and police drop-offs (they will have a secure setting for violent/self-harming patients). They will include: (1) 23-hour mental health (stabilization) and substance misuse (social detox) observation units; (2) high acuity short-term residential treatment units; and (3) case management and assisted care transitions and transportation. It is recommended that the centers be located in Davis, Salt Lake, and Utah counties.	HB 32 (2020) provided initial funding for Utah's community-based behavioral health receiving centers. This funding was later enhanced through the Statewide Behavioral Health Crisis Response Account (SB 155, 2021). These bills support the creation of four community-based behavioral health receiving centers across the state of Utah. Additionally, DSAMH, the Division of Medicaid and Health Financing, LMHAs, and Local Substance Abuse Authorities (LSAAs) worked together to establish a bundled rate for Medicaid reimbursement of services provided at the centers. This reimbursement helps to ensure ongoing financial sustainability of the centers. Two of the receiving centers, located in Davis and Utah counties, have been built and are currently in operation. The Salt Lake County receiving center (Campus of Hope at the Huntsman Mental Health Institute, HMHI) is in development, and construction of the Washington County receiving center is starting.

#	Recommendation	Status
Subacute Care		
11	**Seek a Medicaid mental health institution for mental diseases (IMD) waiver.** Seeking a mental health IMD waiver will allow Utah Medicaid to reimburse mental health residential treatment centers with more than 16 beds for stays less than 15 days.	HB 219 (2020) required UDOH to submit a waiver to allow the Utah Medicaid program to reimburse mental health residential treatment centers with more than 16 beds for stays less than 15 days. The waiver was submitted on July 31, 2020 and has been approved by CMS. Participating entities are required to receive accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission.

#	Recommendation	Status
Acute/Inpatient Care		
12	**Expand capacity at the Utah State Hospital by reopening the closed 30-bed unit and supporting the development of assertive community outreach treatment teams (ACOTTs) and a housing assistance voucher program.** While the capitated Medicaid behavioral health program has been highly effective in maintaining a low number of inpatient bed days, the need for additional state hospital beds is increasing with the state's population. To address this issue, it is recommended that Utah reopen the 30-bed unit currently not being utilized at the Utah State Hospital and continue to study the long-term needs for additional adult beds. ACOTTS are mobile teams comprising medical and mental health professionals that provide assertive community outreach treatment and support patients discharged from the Utah State Hospital. These teams coordinate with other medical providers and community resources to ensure patients have continued access to treatment and appropriate wraparound services and supports. For example, patients receiving assertive community outreach treatment will have access to a housing assistance voucher program that operates in consultation with the Utah State Hospital and one or more housing authorities, associations of governments, or nonprofit entities.	HB 35 (2020) included funding for the 30-bed unit at the Utah State Hospital and required the Forensic Mental Health Coordinating Council to study ongoing capacity needs. HB 35 (2020) also created assertive community treatment (ACT) teams and a housing assistance voucher program for individuals leaving the Utah State Hospital. However, funding for these two programs was pulled back after the 2020 General Session due to competing financial needs from COVID-19. Funding for the additional 30 beds at the Utah State Hospital is scheduled for April 2022 pending current workforce shortage concerns are addressed. Moving forward, more research is needed to evaluate and determine how best to support individuals with high-acuity behavioral health needs in Utah (individuals diagnosed with SMI or serious SUDs who need significant treatments, services, and supports, and often intersect with other state systems, such as the justice system, hospital systems, and housing systems). A key part of this research includes evaluating the role of local government in delivering these services and what resources are needed to provide high-touch, effective care to this population. This includes, but is not limited to, determining how best to provide or coordinate with other entities (e.g., Utah's housing authorities, associations of governments, or nonprofit entities) to develop supportive housing for individuals with behavioral health needs who experience, or are close to experiencing homelessness.

Tier II: Actions to be taken in 2–5 years to allow for continued study, necessary system coordination, or additional structures to be put in place

#	Recommendation	Status
Promotion and Prevention		
1	**Increase the use of behavioral health screenings with referral supports.** Behavioral health screenings assess individuals, identify behavioral health risks, and allow for early interventions that help prevent escalation. UHA's goal is to provide easy access to screenings as well as ensure providers who use these screenings have the support for providing appropriate follow-up treatment (Tier I recommendations #6 and #7) and referral supports (Tier I recommendations #4 and #8). Providing this support will help ensure providers are confident in performing behavioral health screenings and helping patients access the care they need.	Legislative and state agency initiatives have helped increase the use of and availability of behavioral health screenings. For example: • HB 323 (2020) requires the use of age-appropriate mental health/suicide screeners in schools. • DSAMH provides access to private mental health screenings on its website as well as information on how to connect with local mental health resources. • All of Utah's local mental health and substance abuse authorities also provide online information about how to access behavioral health screenings and resources. • Ensuring appropriate referrals for individuals with serious behavioral health concerns is a key goal for the Psychiatric Consultation Program (CALL-UP) detailed below (Tier II, Recommendation #3). • Several of Utah's health systems have, or are working toward, integrating behavioral health screenings into their clinical care processes.

#	Recommendation	Status
Community Education & Services		
2	**Increase use of Botvin LifeSkills Training in 8th and 10th grade classrooms and link with school district-provided parent seminars and other behavioral health promotion activities.** Botvin LifeSkills Training (LST) is an evidence-based substance use and violence prevention program. It has been extensively tested and proven effective at reducing tobacco, alcohol, opioid, and illicit drug use by as much as 80%. For more information, see https://www.lifeskillstraining.com/.	Use of Botvin LifeSkills Training is currently required in 8th and 10th grade classrooms in Utah. As noted above, expanding access to school-based behavioral health services is an important focus of the Utah Legislature and the State of Utah. It is a key priority for DSAMH, which is actively coordinating efforts with USBE, Utah's LEAs, and Utah's LMHAs to ensure students in need have access to a variety of behavioral health services, supports, and referrals, including general health and wellness, screenings, social skills and education, crisis services, counseling, clinical therapy, and medication management. DSAMH will continue to work with LEAs, LMHAs, and the Education and Mental Health Coordinating Council (HB 288, 2021) to build out access to these services to help prevent and address behavioral health concerns and support the emotional well-being of Utah's students.

#	Recommendation	Status
Integrated Physical & Mental Health Care		
3	**Expand the Psychiatric Consultation Program.** The Psychiatric Consultation Program provides primary care providers with access to telehealth psychiatric consultations (peer-to-peer consulting) for patients ages 24 and younger. UHA recommends evaluating the need to continue the Psychiatric Consultation Program based on the implementation of other recommendations and integrated care models. If it is determined appropriate to continue this program, UHA recommends possibly expanding the mentoring component to include adult psychiatry as well.	HB 393 (2019) established the Psychiatric Consultation Program Account10 and HB 337 (2021) expanded the Account to include consultations for early psychotherapeutic services. DSAMH contracted with HMHI at the University of Utah to administer the Psychiatric Consultation Program, which is referred to as CALL-UP. "The goals of the program are to: 1. Optimize primary care providers' ability and confidence to diagnose and treat mild to moderate mental health issues; 2. Improve quality of care and health outcomes for patients by affording early interventions; 3. Promote and improve mental health and physical health integration; and 4. Ensure appropriate referrals for individuals with serious behavioral health concerns." For more information go to: https://healthcare.utah.edu/hmhi/programs/call-up.php DSAMH will continue to work with CALL-UP to increase program uptake through improved marketing strategies and partner connections. DSAMH will also work with CALL-UP to expand the types of providers and target age ranges served by the program, an expansion which has been supported by HMHI and through private contributions.

#	Recommendation	Status
Outpatient Specialty Services		
4	**Improve behavioral health outcomes through increased use of evidence-based practices.** UHA recommends increasing the availability of evidence-based behavioral health treatments by providing funding and direction to DSAMH to implement evidence-based practice training and monitoring.	Implementing evidence-based practices is an ongoing priority for DSAMH and the division has long-been studying, utilizing, promoting, and providing access to trainings on evidence-based practices. For example, HB 337 (2021) provided funding to DSAMH to support training and education for child care providers on child behavioral health and best practices for early child mental health support and interventions. DSAMH will continue to promote and provide trainings on evidence-based practices related to outpatient specialty services and other areas across the continuum of behavioral health services and supports. More research is needed, however, to evaluate what role the State should have in promoting vs. encouraging vs. mandating and monitoring evidence-based practices—and what additional resources are needed to support this role. This topic will be addressed as part of the master plan for improving Utah's behavioral health system. For example, the master plan could assess how to best use quality improvement processes to help ensure fidelity to evidence-based practices. It could also provide recommendations on how to ensure use of evidence-based practices is consistent across public and private providers.

#	Recommendation	Status
Subacute Care		
5	**Create a reimbursement mechanism for intensive residential housing managers.** UHA recommends seeking a Medicaid waiver or state plan amendment to allow supported housing providers to bill Medicaid a daily rate for live-in companions or other supported-living workers when the resident is disabled.	This reimbursement mechanism has not yet been established, but a Medicaid waiver could be sought independently by UDOH or required by state statute. More research is needed, however, to determine how broad or narrow to make the focus of the waiver and the populations it would cover. For example, should the waiver extend to multiple populations and services such as individuals with high-acuity behavioral health needs, persons with disabilities who have co-occurring behavioral health needs, the aging population, and/or the homeless?

Tier III: Promising solutions, but need further research to fully understand the impact

#	Recommendation	Status
Stabilization Supports and Wraparound Services		
1	**Develop a plan to expand Stabilization and Mobile Response (SMR) services to the rest of the state.** DHS and it's divisions, in collaboration with LMHAs, the Division of Juvenile Justice Services, and the Division of Child and Family Services, provides SMR services to children, parents, caregivers, and families in their homes. These services ease behavioral health crises, offer family preservation strategies, and provide support for making environmental modifications. SMR services help keep children and youth in their homes, schools, and communities when possible.	HB 337 (2021) provided $1 million in ongoing funding to extend Utah's SMR services to Utah's Western region (Utah, Wasatch, Juab, Millard, Sevier, Sanpete, Piute, and Wayne counties). SMR is now operational in all of Utah's five System of Care regions (but not all counties). While some of the regions are supported by state funding, others are funded through private donations or grants. DHS recently awarded the Western region SMR contract (funded by HB 337). It is working to sustain the in-kind donation from Pri mary Children's Hospital (Intermountain Healthcare), which supports the Salt Lake region and expired in October 2021. It is also working to sustain funding for the Eastern region, which is currently funded through a SAMHSA System of Care Expansion and Sustainability grant that ends September 2024. Moving forward, SMR is also planning to transition away from the term "crisis" to "challenge" as it positions itself to better provide families with tools and resources that address their unique needs earlier on (before a challenge becomes a crisis). It is also increasing its focus and outreach to families with young children by building partnerships with school districts, child care organizations, and other community-based organizations serving underserved populations.

#	Recommendation	Status
Community Education & Services		
2	**Improve coordination between community- and school-based behavioral health services and the broader behavioral health and medical health care systems.** Many community- and school-based behavioral health services are provided in silos, disconnected from the broader behavioral health and medical health care systems. To improve the integration of physical and behavioral health, and improve schools' access to more behavioral health services, resources, and supports, UHA recommends creating stronger connecting points between primary care, school-based services, and existing behavioral health and medical health care systems. This process would include developing clear goals and outcome measures to monitor success.	As noted in Tier I, Recommendation #5, expanding access to school-based behavioral health services to students in need was a key focus for the Utah Legislature in 2019, 2020 and 2021. As part of this expansion, the Legislature sought to improve coordination between community- and school-based behavioral health services and the broader behavioral health and medical health care systems through HB 288 (2021). This bill created the Education and Mental Health Coordinating Council, which will develop recommendations regarding behavioral health supports provided to youth and families across the state. Council meetings formally began in October 2021. As also noted above, DSAMH is assessing access to and availability of behavioral health services in Utah's K–12 schools in order to identify gaps in services. DSAMH will continue to work with LEAs, LMHAs, and the Education and Mental Health Coordinating Council to build out access to school-based behavioral health services, supports, and referrals to help prevent and address behavioral health concerns and support the emotional well-being of Utah's students. Moving forward, UHA and DSAMH see a need to connect this recommendation with Tier III, Recommendation #5, which is to study effective ways to address behavioral health workforce shortages. Increasing school-based behavioral health services and resources has come at a cost to behavioral health clinics and other providers as they now compete with schools for the same limited workforce. It also connects to the need to promote increased use of telehealth (Tier III, Recommendation #6) and ensure adequate reimbursement rates for Utah's behavioral health workforce (Tier I, Recommendation #3 and Tier III, Recommendation #7). This topic will be addressed more extensively in the master plan for improving Utah's behavioral health system. For example, one possible solution the master plan could explore is finding ways for people to work at the top of their clinical licenses to better cultivate a workforce with a diverse number of degrees.

#	Recommendation	Status
Integrated Physical & Mental Health Care		
3	**Study policy, program, or state statute changes to reduce the barriers created by the state requirement that Utah's county governments match Medicaid behavioral health services.** Current state law requires counties to fund a portion of the state share of Medicaid costs for behavioral health services. This limits the ability of Medicaid to find alternative ways of delivering these services to Medicaid-eligible individuals. UHA recommends reviewing state statutes[11] and evaluating possible changes. Any proposed policy and program changes must protect safety net behavioral health funding for services provided to the uninsured and indigent populations as well as address the risk that the counties currently assume with regard to civil commitment and assisted outpatient treatment.	This process was delayed as a result of the UDOH/DHS consolidation. The need for this study will be evaluated in the context of Utah's new health and human services department in SFY2023.

#	Recommendation	Status
4	**Study evidence-based, regionally appropriate integrated care models and evaluate possible options to recommend.** UHA supports the creative development of evidence-based, regionally appropriate models. Possible models to be evaluated could include but are not limited to: physical health-based medical homes, behavioral health-based medical homes, Cherokee Health Systems, the Collaborative Care model, co-location, and improved partnerships and collaborations. Possible payment mechanisms used to support these models could include, but are not limited to: increasing the base rate for providers, using capitated codes that encompass both physical and behavioral health services, and using value-based payments for integrated physical and behavioral health services. UHA supports research that identifies: (1) current systems using integrated care or screening models that address "whole-person health care;" (2) barriers that restrict the use of integrated care; (3) the impact on costs (i.e., short-term cost increases v. long-term cost savings); (4) necessary resources to pilot select models and expand successful models statewide; and (5) forums or other mechanisms to connect and educate providers on the outcomes of this research.	On January 1, 2020, the State of Utah launched the Utah Medicaid Integrated Care (UMIC) program, which manages adult Medicaid expansion members' physical and behavioral benefits through integrated managed care plans. The program currently operates in five counties. The State is preparing to receive results from UMIC's first year of program data, which will be formally evaluated and shared over the next couple of years. As part of its efforts to promote the development of evidence-based, regionally appropriate integrated care models, UHA plans to support the continued sharing of results and lessons learned from different models during its behavioral health committee meetings. It will also continue to evaluate if or when more formal research is needed, as well as what forums can be leveraged or created to more broadly share existing and new research.

#	Recommendation	Status
Outpatient Specialty Services		
5	**Study effective ways to address behavioral health workforce shortages.** UHA is continuing to evaluate ways to address Utah's shortage of behavioral health providers. In addition to the other workforce-related recommendations included in this report, UHA is assessing options such as increasing psychiatry residency slots at the University of Utah School of Medicine; expanding the scope of practice of certain providers such as Advanced Practice Registered Nurses (APRNs), Licensed Clinical Social Workers (LCSWs), School Social Work Specialists (SSWSs), Clinical Mental Health Counselors (CMHCs), and Licensed Marriage and Family Therapists (LMFTs); providing state-funded rural area workforce incentive grants; and providing state-funded loan forgiveness/tuition reductions for rural areas.	As noted above, studying effective ways to address Utah's behavioral health workforce shortages will be a key component of the master plan for improving Utah's behavioral health system. Utah has long experienced behavioral health workforce shortages that have been exacerbated by provider burn-out during COVID-19, rapid population growth, and increasing serious behavioral health needs. That said, work is currently being done by the Legislature and different state agencies to better understand and address Utah's shortages. For example, HB 246 (2020) funded 16 additional psychiatry resident spots. Using appropriations allocated in the special session of June 2020, the University of Utah and Utah State University expanded their Master of Social Work programs by 70 student slots in order to increase the number of licensed clinical social workers (LCSWs) in Utah (student slots were increased in Salt Lake County at the University of Utah and in rural areas through Utah State University's satellite campuses). Governor Cox's One Utah Roadmap includes an action item to "develop a plan to maintain and improve rural loan repayment, the Rural Physician Loan Repayment Program, and the Health Care Worker Financial Assistance Program."[12] [13] Proposed initiatives for the One Utah Roadmap include expansion of higher education, ongoing funding for the loan repayment program, and multicultural- and minority-relevant financial assistance for underserved communities. As part of this process, USAAV+ is working with the Utah Legislature in preparation for the 2022 General Session to implement a compact that would allow licensed clinical mental health counselors in other states to practice across state lines in order to increase public access and continuity of care. Finally, the Utah Medical Education Council (UMEC) released an updated report on Utah's Mental Health Workforce 2021. This report provides a baseline that can be used to develop recommendations and strategies for addressing Utah's behavioral health workforce shortages.
6	**Promote increased use of telehealth, telemedicine, and telepsychiatry.** To promote increased use of telehealth, telemedicine, and telepsychiatry, UHA recommends evaluating the availability, use, and reimbursement of existing telehealth codes used in Medicaid and by other public and private payers.	One possible silver lining that emerged from the COVID-19 pandemic was the increased use of telehealth, telemedicine, and telepsychiatry. The Legislature supported this increased use through SB 161 (2021), which requires coverage for mental health and SUD telehealth services. (Note: Utah's self-funded health insurance plans, which make up about 40% of Utah's health insurance market, are not impacted by this policy.)[14] Medicare also increased the number of services that could be delivered through telehealth during the public health emergency, and is starting to make some of these changes permanent. To ensure that the use of telehealth, telemedicine, and telepsychiatry remains viable, DSAMH, UHA, and other key stakeholders continue to explore the development of additional legislative language to help secure reasonable reimbursement rates for these telehealth services. This aligns with Governor Cox's One Utah Roadmap, which includes an action item to "Expand telehealth, focusing on mental health and substance abuse."[15] [16]

#	Recommendation	Status
7	**Increase public mental health funding and resources, with a focus on (1) changing state statute to allow for inflationary increases in Utah's Medicaid and public behavioral health system, and (2) enacting policy changes to improve base safety net funding and ensure funding for critical services.** Possible solutions could include establishing a statutorily set inflationary increase for Utah's Medicaid prepaid mental health plans (similar to the annual increase provided to Utah's Medicaid ACOs, or moving to a consensus funding process.	Beginning July 1, 2022, SB 161 (2021) requires an inflationary increase for Utah's Medicaid prepaid mental health plans. The Division of Medicaid and Health Financing 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 Federal Medical Assistance Percentages, FMAP). Additional clarification may be needed for this recommendation to be fully realized. As noted in Tier I, Recommendation #3, this is a priority area for the State moving forward and will be part of a larger initiative to determine whether the reimbursement rates for behavioral health providers and services in Utah are sufficient to support and maintain an adequate workforce.
8	**Improve commercial coverage of behavioral health services.** While Medicaid and the public health system provide a significant amount of mental health services, most Utahns have commercial health insurance. UHA recognizes that improving coverage for middle-class families is imperative and requires additional study. This could include evaluating ways for the Department of Insurance to (1) improve enforcement of mental health parity, (2) encourage plans that are not subject to mental health parity laws to cover behavioral health services, and (3) help consumers understand the potential impact new federal rules regarding Short-Term, Limited-Duration plans will have on behavioral health coverage. Other areas of possible study include designating "essential community services" (i.e., crisis call centers, MCOTs, receiving centers, etc.) and requiring these services be covered by all health insurance plans or be funded in a broad-based way, and evaluating ways to improve behavioral health coverage in self-funded plans.	As noted above, SB 161 (2021) requires coverage for mental health and SUD telehealth services for public and some commercial health insurance plans. HB 313 (2020) requires comprehensive health insurance plans to provide coverage and reimburse contracted providers for telehealth services and telemedicine services at a commercially reasonable rate. As also noted above, DSAMH, UHA, and other key stakeholders continue to explore the development of additional legislative language to help secure reasonable reimbursement rates to maintain the financial viability of telehealth services. Moving forward, it is recommended the State continue to focus on improving commercial health insurance coverage of treatments, services, and supports across the full behavioral health continuum. This could include, but is not limited to encouraging health insurance plans that are not subject to mental health parity laws to cover behavioral health services, evaluating ways to improve behavioral health coverage in self-funded plans, and improving the behavioral health benefit packages offered by health insurance plans.

#	Recommendation	Status
9	**Evaluate the behavioral health needs of specific populations and study ways to improve behavioral health services for these targeted groups.** More research should be conducted on the behavioral health needs of children, seniors, and other targeted populations as well as what policy and program changes can address their needs.	DSAMH continues to prioritize research and evaluation of the behavioral needs of specific populations such as children, seniors, and other targeted groups. These reports include recommendations for improvement. Examples of the division's research include, but are not limit to: • Health Disparities in Utah's Public Mental Health and Substance Use Treatment Systems: A Needs Assessment • Utah LGBTQ+ Suicide Prevention Plan: 2020-2023 • 2021 Student Health and Risk Prevention (SHARP) Needs Assessment Survey Results • Utah Suicide Prevention State Plan 2022-2026 (more information on the State Plan and supporting documents can be found at liveonutah.org/about) • Suicide and Accidental Drug Overdose Rates during the COVID-19 Pandemic DSAMH and UHA support targeted evaluations of other groups' behavioral health needs, including, but not limited to, the senior population, individuals with high-acuity behavioral health needs, individuals with co-occurring behavioral and physical health needs or disabilities, and other historically underserved populations such as the LGBTQ+ population and black and indigenous people of color. In terms of children, UDOH produced a report on Adverse Childhood Experiences in Utah and the Kem C. Gardner Policy Institute developed a report assessing Early Childhood Mental Health in Utah in 2020. The Children's Center Utah used the findings from these and other reports to better understand the gaps and challenges in Utah's early childhood mental health system, and has engaged a working group to develop strategies for improvement. A draft of these strategies is expected to be released in December 2021 and will be presented to the Education and Mental Health Coordinating Council (HB 288, 2021).
10	**Establish six- or 12-month continuous eligibility for certain Medicaid populations with behavioral health needs.** Medicaid eligibility is reviewed and determined monthly for most Medicaid populations. Establishing continuous eligibility for certain Medicaid populations with behavioral health needs will help ensure they can continue to access necessary care as they receive treatment and achieve stability.	12-month continuous eligibility for children was passed and funded during the 2020 General Legislative Session. However, funding for this programs was pulled back after the 2020 General Session due to competing financial needs from COVID-19. It may be brought forward for consideration in the 2022 General Session. Providing 12-month continuous eligibility for Medicaid and CHIP is also included in the federal Build Back Better Act, which would require all states to implement 12 months of continuous eligibility for children under age 19 in both Medicaid and CHIP.

#	Recommendation	Status
Subacute Care		
11	**Explore ways to stimulate continued growth of subacute beds.** Given the growing demand for subacute services in the state, UHA recommends continued research and discussion of financially sustainable ways to stimulate the growth of subacute beds in Utah.	As noted in Tier I, Recommendation #10 (community-based behavioral health receiving centers) and Recommendation #11 (mental health IMD waiver), the State has taken some preliminary steps to stimulate continued growth of subacute beds in Utah. For example, the receiving centers in both Davis and Utah counties provide some subacute capacity through the use of recliners, beds, and other services. Once open, the receiving centers in Salt Lake and Washington counties will provide similar subacute services. Private treatment and transitional housing centers, like the Sober Living Properties and Addiction Programs, also offer some subacute care in Salt Lake County. In addition, the State of Utah is using funds ($5.3 million) from the American Rescue Plan Act of 2021 to develop infrastructure that will support transitional housing. While this does not directly address growth of subacute beds, it allows people to leave the subacute system and enter support housing, making subacute beds more accessible to those in need. It is recommended the State continue to explore ways to stimulate continued growth of subacute beds as part of its effort to determine how best to support individuals with high-acuity behavioral health needs. Part of this includes evaluating the most pressing high-acuity behavioral health needs within Utah's behavioral health system and what care settings are required to address those needs. It also includes evaluating how best to stimulate growth of high-acuity behavioral health services outside of Salt Lake County (limited options currently exist in rural Utah, despite the growing need for these services).

#	Recommendation	Status
Acute/Inpatient Care		
12	**Evaluate the possibility of creating a step-down, long-term-care mental health facility for state hospital and other patients with ongoing behavioral health needs.** This facility could provide residential care to patients who require long-term custodial care (e.g., state hospital patients who are not able to be restored to competency) or patients with co-occurring mental health diagnoses and intellectual or developmental disabilities (IDD) who cannot safely reside in the community, but are not suited for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID) or Skilled Nursing Facilities (SNF) due to their level of physical aggression or other risk factors.	DSAMH and the Division of Medicaid and Health Financing have been meeting with a few nursing home facilities to discuss what reasonable rates would be needed for them to provide step-down or interim care for state hospital and other patients with ongoing behavioral health needs. DSAMH and the Division of Medicaid and Health Financing are also beginning to look into how to provide this benefit to Medicaid enrollees, whether and what level of appropriation would be required, as well as obtaining CMS approval through the Medicaid waiver process.
13	**Study ways to mitigate forensic creep at the Utah State Hospital.** As part of studying the long-term needs for additional adult beds at the Utah State Hospital (Tier I Recommendation #12), UHA recommends evaluating the impact of opening more forensic units on civil bed capacity.	As noted above, HB 35 (2020) required the Forensic Mental Health Coordinating Council to study ongoing capacity needs at the Utah State Hospital. The report was finalized in October 2020.

Tier IV: Create structures to sustain behavioral health system improvements over time

#	Recommendation	Status
1	**Establish regular stakeholder meetings with DSAMH.** To ensure ongoing, coordinated improvements to Utah's behavioral health system, UHA recommends DSAMH host regular stakeholder meetings to discuss (1) the behavioral health needs of adults and children across the state; (2) any progress, problems, or proposed plans related to behavioral health services; and (3) identified gaps in behavioral health services and recommendations or service enhancements to address those gaps. Meeting participants should include stakeholders and industry representatives from across the state (e.g., LMHAs, ACOs, behavioral health providers, researchers, and patients and community advocates).	UHA's behavioral health committee continues to regularly meet with representatives from DSAMH to discuss the behavioral health needs of adults and children across the state, any progress, problems, or proposed plans related to behavioral health services, identified gaps in behavioral health services, and recommendations or service enhancements to address those gaps, among other issues. DSAMH representatives also meet with Utah's Behavioral Health Planning and Advisory Council (UBHPAC) as well as participate in other state and community-based councils such as USAAV+, the Utah Crisis Response Commission, the Utah Association of Counties (UAC), the Utah Behavioral Healthcare Committee (UBHC), One Utah Roadmap subcommittees, and UDOH/DHS consolidation committees and stakeholder meetings, among others.
2	**Encourage state leaders to engage with Utah's federal representatives to support changes in federal behavioral health law.** Topics could include, but are not limited to: (1) modernizing the information privacy requirements of 42 CFR Part 2, (2) addressing opioid use disorder providers' prescribing limits (physicians can only treat a limited number of patients), and (3) removing the Medicaid mental health IMD exclusion in its entirety.	DSAMH and UHA continue to monitor changes in federal behavioral health law and work with state leaders to support changes as appropriate. For example, DSAMH closely followed modifications in opioid use disorder provider and service requirements stemming from the COVID-19 public health emergency (PHE). It continues to follow federal policy to understand how these modifications will be impacted once the PHE ends and is analyzing data to understand the potential impact on access to services, overdose numbers, and overdose types throughout the state. DSAMH is also following federal rule changes that could impact HIPAA and 42 CFR. In addition, new federal regulations regarding mobile methadone services are being reviewed and coordinated for potential implementation. Another key example is the State of Utah's work with its federal representatives to establish 988 as a nationwide 3-digit number for mental health crisis and suicide prevention services. Representative Chis Stewart (R-UT-2) introduced the National Suicide Hotline Improvement Act of 2018 (H.R.2345), which set into motion the National Suicide Hotline Designation Act of 2020 (S.2661) and the establishment of 988. (See Tier I, Recommendation #8 for more detail).
3	**Sustain the promotion and development of behavioral health evidence-based practices.** Develop and fund a statewide Behavioral Health Care Center of Excellence tasked with aligning behavioral health organizational infrastructures (e.g., training, supervision, data collection) to support the effective implementation of evidence-based treatments.	As mentioned in Tier II, Recommendation #4, implementing evidence-based practices is an ongoing priority for DSAMH and the division has long been studying, utilizing, promoting, and providing access to trainings on evidence-based practices. That said, more research is needed before establishing a statewide Behavioral Health Care Center of Excellence in order to evaluate who should operate this center and what role the State should have in promoting vs. encouraging vs. mandating and monitoring evidence-based practices. This topic will be addressed as part of the master plan for improving Utah's behavioral health system.

Appendix:

Utah Health Systems and Organizations Participating in the Zero Suicide Initiative

Bear River Mental Health
Blomquist Hale Employee Assistance Program (EAP)
Bonneville Family Practice
CAPSA
Central Utah Counseling Center
Davis Behavioral Health
Family Place Utah
Four Corners Behavioral Health
Health Clinics of Utah
Hill Air Force Base
Huntsman Mental Health Institute (University Neuropsychiatric Institute)
In Tune Counseling and Coaching
Intermountain Healthcare
Intermountain Employee Assistance Program (EAP)
Latino Behavioral Health Services
LDS Family Services
Mountain Star Healthcare
Northeastern Counseling Center
Odyssey House
Optum
Provo Canyon School
Salt Lake Behavioral Health
Salt Lake County Behavioral Health
San Juan Counseling
Southwest Behavioral Health
Steward Health Care
Summit County Health Department
The Haven
University Of Utah Crisis Services
University of Utah Health
Utah Department of Human Services, System of Care
Utah Department of Human Services, Division of Juvenile Justice Services
Utah Navajo Health System
Utah Partners for Health
Utah State Hospital
Utah Valley University
Utah Youth Village
Valley Behavioral Health
Veterans Affairs Utah
Wasatch Behavioral Health
Weber Human Services

Endnotes

1. Utah's Mental Health System: Progress Report. (2021 April, 1). Office of Legislative Research and General Counsel.
2. Grading the States: An Analysis of Involuntary Psychiatric Treatment Laws. (2020 September). Treatment Advocacy Center. Available from https://www.treatmentadvocacycenter.org/grading-the-states
3. One Utah Roadmap: Version 1. (2021, January 19). Governor Spencer J. Cox and Lt. Governor Deidre M. Henderson. Available from https://drive.google.com/file/d/1ql9q5pNKYXDnIlcWk4wcIPmxOhaHFgSd/view
4. One Utah Roadmap: Version 2. (2021, October 20). Governor Spencer J. Cox and Lt. Governor Deidre M. Henderson. Available from https://drive.google.com/file/d/1xnI1ETQOGGNXYsj4rm4dm-7726JAfbmr/view
5. Intermountain Healthcare Selects the "Unite Us" Platform to Digitally Connect Medical and Social Service Providers. (2019 March 10). News Release. Intermountain Healthcare. Available from https://intermountainhealthcare.org/news/2019/03/intermountain-healthcare-selects-the-unite-us-platform-to-digitally-connect-medical-and-social-service-providers/
6. Utah's Tenth Annual Report. Intergenerational Poverty: Welfare Dependency and Public Assistance Use. (2021 September 28). Utah's Intergenerational Welfare Reform Commission. Available from https://jobs.utah.gov/edo/intergenerational/igp21.pdf
7. 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
8. HB 32 (2020) provided $13.6 million in ongoing and one-time funding to be allocated between the crisis and warm lines and the receiving centers.
9. SB 155 (2021) provided approximately $4.2 million in ongoing funding to be allocated between the crisis and warm lines and SafeUT.
10. HB 393 (2019) also requires DSAMH to provide grants from the account ($275,000 of ongoing funding).
11. 1743.201 and 1743.301 and 62A-15 (62A-15-629 through 62A-15-713).
12. One Utah Roadmap: Version 1. (2021, January 19). Governor Spencer J. Cox and Lt. Governor Deidre M. Henderson.
13. One Utah Roadmap: Version 2. (2021, October 20). Governor Spencer J. Cox and Lt. Governor Deidre M. Henderson.
14. The telehealth platform used must compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in order to be reimbursed. The legislature also passed SB 41 (2021), which was superseded by SB 161, and HB 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.
15. One Utah Roadmap: Version 1. (2021, January 19). Governor Spencer J. Cox and Lt. Governor Deidre M. Henderson.
16. One Utah Roadmap: Version 2. (2021, October 20). Governor Spencer J. Cox and Lt. Governor Deidre M. Henderson.

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UHA

UTAH HOSPITAL ASSOCIATION

www.UtahHospitals.org

A goal of the Utah Hospital Association (UHA) is to develop recommendations and support legislation to ensure every citizen in the state of Utah has access to appropriate behavioral health services and supports.

utah department of human services

SUBSTANCE ABUSE AND MENTAL HEALTH

The mission of the Utah Department of Human Services, Division of Substance Abuse & Mental Health is to promote health, hope, and healing from mental illness and substance use disorders.

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