UTAH HOSPITAL ASSOCIATION

A Roadmap for Improving Utah's Behavioral Health System

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Contents

The Problem

Utah is in the midst of a behavioral health crisis. High suicide rates, untreated anxiety and depression, serious mental illness, and high rates of opioid use disorder and other drug-related deaths are all signs of the need for accessible, affordable, and comprehensive behavioral health services.

However, many Utahns do not have access to the care they need. Utah has mental health provider shortages in every county and has fewer mental health providers per 100,000 people than the national average. Nearly half of Utah's adults and youth with mental health needs do not receive appropriate services or treatment.

Funding for public mental health services in Utah is bifurcated across different delivery systems, making it difficult to consistently deliver coordinated care, and limited commercial health insurance coverage of mental health care is a major barrier to providing and accessing services. Numerous gaps across Utah's continuum of mental health services and supports prevent Utahns from accessing the right care at the right time.[1]

A lack of timely, integrated, and coordinated services, coupled with stigma around help-seeking, can escalate mental health needs to a crisis. This may result in people receiving mental health care in inappropriate and high-cost settings (such as correctional facilities and emergency rooms). Untreated mental health issues may also continue to place upward pressure on Utah's already high suicide rate.

Utah's experience is part of a national problem, where depression is estimated to cause 200 million lost workdays each year, and serious mental illness results in $193.2 billion in lost earnings.[2]

Figure 1: Mental Health In Utah: Key Statistics

Close to one in five adults experience poor mental health.

Suicide

is the leading cause of death for Utahns ages 10 to 17.

SafeUT

chats increased by more than

54%

between January 2018 and January 2019, and SafeUT tips increased by almost

100%

Veteran suicides

account for **13%** of all suicides in Utah.

Over

100,000

adults in Utah experience Serious Mental Illness (SMI).

Over half

of Utah adults with mental illness did not receive mental health treatment or counseling.

60%

of Utah's depressed youth age 12 to 17 did not receive treatment for depression.

About

15%

of new mothers experience postpartum depression symptoms.

The percent increases to

21%

for low-income mothers.

From: 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. SafeUT statistics from School Safety & Crisis Tip Line. (2019, February). University of Utah Health.

Our Goal

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.

Every citizen in the state of Utah has access to appropriate behavioral health services and supports.

Our Process

UHA Behavioral Health Committee and Mental Health Workgroup

In 2018, UHA established a behavioral health committee to support its goal of ensuring every citizen in the state of Utah has access to appropriate behavioral health services and supports. This committee launched its efforts with an initial focus on mental health services and created a mental health workgroup, comprising key members of the mental health community, to study Utah's mental health system and develop recommendations for improving access to treatment, services, supports, and coordination across Utah's continuum of mental health care (Figure 3).

Utah's Mental Health System Study

In mid-2018, the workgroup commissioned a formal study of Utah's mental health system to support informed discussions and decisions regarding potential solutions and reforms. UHA contracted with the Kem C. Gardner Policy Institute to assess the current state of mental health services in Utah, highlighting gaps in services, barriers to providing and accessing care, and considerations for improving the system.

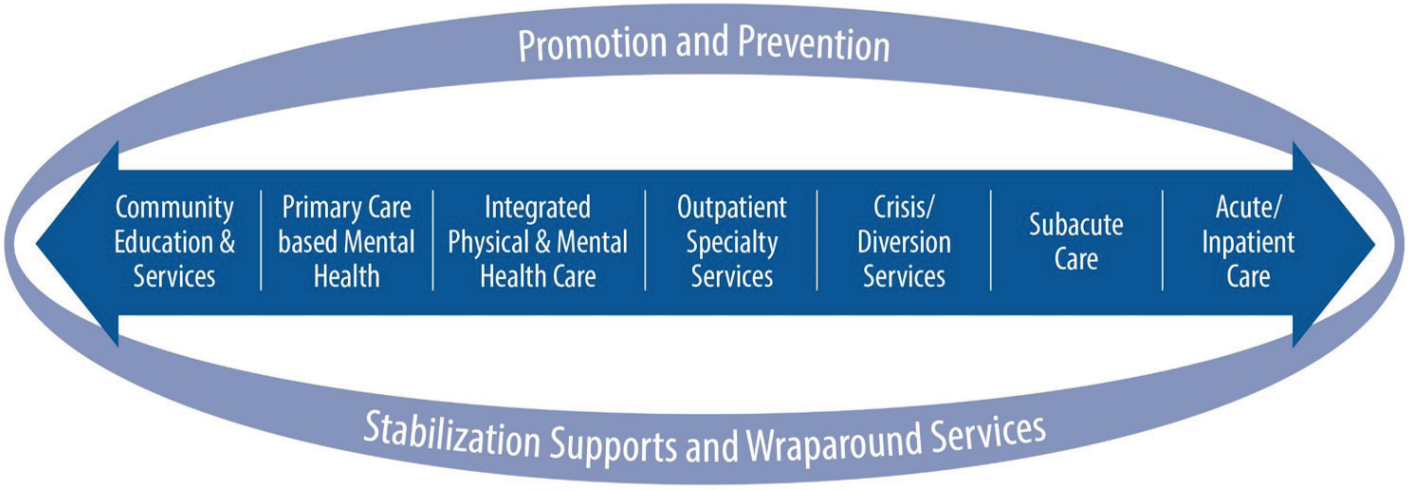
Roadmap Development

Based on the Gardner Institute's report, the workgroup's collective knowledge of the mental health system, and additional assessments from researchers and industry stakeholders, UHA's mental health workgroup developed a proposed Roadmap for Improving Utah's Behavioral Health System.

Figure 2: Utah Hospital Association Mental Health Workgroup Member Organizations

Source: Utah Hospital Association.

Figure 3: Utah's Continuum of Mental Health Care



Source: Utah Hospital Association.
For more details on Utah's Continuum of Mental Health Care, see Appendix 1.

Policy Summit on Mental Health

UHA hosted a Policy Summit on Mental Health in Utah on October 2, 2019, to share the roadmap and initial recommendations with policymakers and other behavioral health stakeholders.

Government, policy, and health care leaders from across the state attended the summit, including Governor Gary Herbert, legislative leaders from Utah's Senate and House, state department directors, health care system leaders, and many others.

Implementation and Legislation

UHA's mental health workgroup used feedback from the policy summit to refine its roadmap and recommendations (outlined in this report). UHA's behavioral health committee will continue to convene stakeholders to oversee the implementation of these recommendations, develop new recommendations, and propose and support legislation that improves Utah's mental health system and larger behavioral health system.

Future Phases

Broader Stakeholder Engagement

Based on interest expressed at the October 2nd summit, UHA is working to coordinate current efforts and future phases of this work with representatives from education, law enforcement, substance use disorder services, the Huntsman Mental Health Institute,[3] and other stakeholders.

Substance Use Disorders

The recommendations included in this report primarily focus on mental health. However, it is important to note that mental health is closely related to substance use disorders (SUD) from a health system and condition perspective. Many of Utah's public health systems provide both mental health and SUD services, and many people with mental health issues have co-occurring SUDs.[4]

While several of the recommendations outlined in this report will positively impact both the mental health and SUD systems in Utah, future phases of UHA's process will specifically focus on identifying gaps and challenges in the SUD system. These phases will include broader stakeholder involvement and developing recommendations that address SUD and behavioral health issues.

In this report, 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.

Substance Use Disorders in Utah: Key Statistics

Drug overdose deaths are the leading cause of injury death in Utah, outpacing deaths due to firearms, falls, and motor vehicle crashes.[5]

53 Utah adults die as a result of a drug overdose every month. Prescription opioids make up half of all accidental and undetermined drug overdose deaths in the state.[6]

Guiding Principles

Four principles helped guide the mental health workgroup's recommendations:

- There are gaps in mental health services and supports across the entire continuum of mental health care in Utah (Figure 3). It is imperative recommendations reflect the full continuum of care to support a robust mental health system.
- Prevention and early intervention are critical. If appropriate mental health services and supports are provided in an early or "upstream" setting, then a person is more likely to have a better quality of life and less likely to move down the continuum to more complex, disruptive, and costly care settings. Prevention and early interventions reach a broader segment of the population at lower costs.
- Improved coordination of mental health services, stabilization supports, and wraparound services are critical to helping people access the right services, at the right time, by the right providers.
- The system should be patient- and family-focused. Creating a system that engages both patients and families is vital for success, particularly when patients are under age 18. A patient- and family-focused system provides natural supports and helps to reduce stigma.

Recommendations

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 mental 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.

Respecting this need for an organized approach to system improvement, UHA's roadmap includes a set of tiered recommendations.

- **Tier I Recommendations** address acute service gaps and care needs in Utah's current behavioral health system. Development, implementation, or funding of these recommendations should occur within the next year, given the critical need for these services and their ability to address broader system issues.
- **Tier II Recommendations** address acute service gaps and care needs in Utah's behavioral health system. Development, implementation, or funding of these recommendations should occur within the next 2-5 years to allow for continued study, necessary system coordination, or additional structures to be put in place for the recommendations to be effective.
- **Tier III Recommendations** are recommendations that seem promising but need further research to more fully understand their impact on Utah's behavioral health system. As an example, UHA supports an assessment of Utah's early childhood mental health system to help inform future discussions and development of pediatric-focused recommendations.
- **Tier IV Recommendations** focus on sustaining continual improvements to Utah's behavioral health system over time. Improving Utah's behavioral health system is not a short-term, one-size-fits-all issue. It requires ongoing, systematic evaluation of ways to improve coordination of services and systems at a regional and state level as new services are developed, and existing policies and regulations change. It requires breaking down barriers and providing ongoing support to ensure the system is moving toward improvements in a coordinated way.

TIER I — Immediate actions to address acute care needs.

Tier I recommendations are provided on pages 5–9. Some recommendations require legislation and state appropriation, while others only require system engagement and collaboration. Each recommendation is coded to indicate what actions the recommendation requires for implementation.

UHA's behavioral health committee is evaluating and refining the implementation plans for the recommendations. Because program details, resource needs, and funding requests can rapidly change during this process, this report includes only summary details on each recommendation. For more information about these recommendations, please contact UHA.

Requires legislation and state appropriation

Requires Medicaid program changes

Requires commercial insurance changes

Requires health system engagement/collaboration

Positively impacts Utah's SUD system

Promotion and Prevention

1 **Continue to increase the number of health care systems participating in Zero Suicide.**

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.

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.**

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.

Figure 4: Community Health Workers and Digital Platforms Connect Patients to Stabilization Supports and Wraparound Services

Source: Intermountain Healthcare.

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).**

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.

Primary Care Based Mental Health Helps Fill Coverage Gaps

Commercial health insurance coverage of mental health services is often limited. Not all commercial health insurance plans are required to cover mental health services—and even if they do, there are still applicable copays and deductibles, which can result in high out-of-pocket costs.[7]

This limited coverage leaves many "middle class" families in Utah with little access to mental health services beyond what they can obtain through their primary care physician. Primary care–based mental health can help meet these families' mental health needs before they escalate to more expensive care settings.

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.[8] 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.

Integrated Care Helps Improve Access to Mental Health Services and Address Workforce Shortages

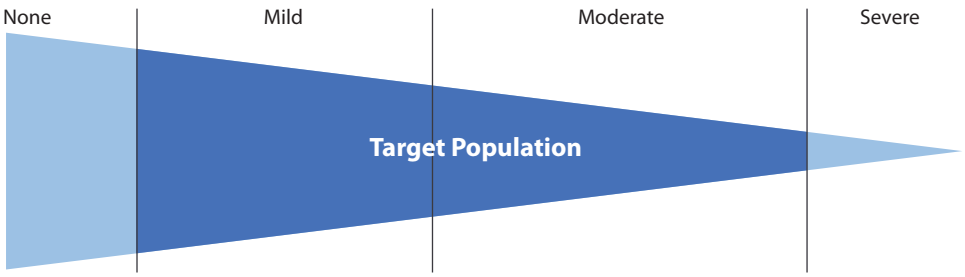
A key gap in Utah's mental health system is the large-scale integration of physical and mental health care. Promoting integrated care models with targeted referrals to specialty mental health care is critical to improving access to mental health services as well as addressing workforce shortages.

Integrated care models are varied, and different approaches should be utilized based on each health system's needs. While some recommended approaches are provided in this report, UHA supports the continued use of existing integrated care models as well as the creative development of evidence-based, regionally appropriate models. For examples of successful models that currently exist in the state, see Appendix 2.

UHA also plans to continue to study possible policy, program, and state statute changes to improve the integration of physical and mental health services provided to Medicaid members.

Figure 5: Target Population for Primary Care Based Mental Health and Integrated Care Models

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.[9]



Source: Raney, L. M.D. (2016). Applying the Integrated Care Approach: Integrating Primary Care and Behavioral Health. American Psychiatric Association. Available from: https://www.ncpsychiatry.org/assets/2016AnnualMeeting/Handouts/1_integrating_primary_care_and_behavioral_health-lori_raney.pdf.

Crisis/Diversion Services

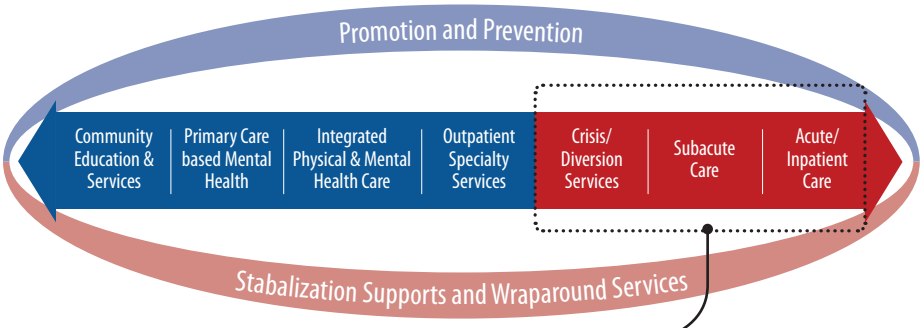
Crisis services are an important part of Utah's mental health care continuum (Figure 6). Crisis services help stabilize patients so they can more fully engage in treatment and move to a self-sustaining recovery.

Utah currently lacks a well-coordinated crisis system. An analysis by RI International Consulting, commissioned by the Utah Department of Human Services, found that Utah's existing crisis system relies heavily on emergency rooms and law enforcement to provide crisis services.[10]

Crisis and diversion services, like crisis contact and referral centers and mobile crisis outreach teams, prevent mental health issues from escalating to the point where patients require subacute or acute inpatient care. These services help stabilize more people earlier on, at a lower cost, reducing overall costs in the health care system. See Figure 6 for the estimated effect of implementing a well-coordinated crisis system in Utah.

While Utah currently has pieces of a coordinated crisis system in place, these services need to be continued, expanded, and enhanced to more effectively achieve the model illustrated in the lower half of Figure 6. Initial recommendations to improve Utah's crisis system are outlined on page 8.

Figure 6: Crisis Services Are an Important Part of Utah's Mental Health Care Continuum

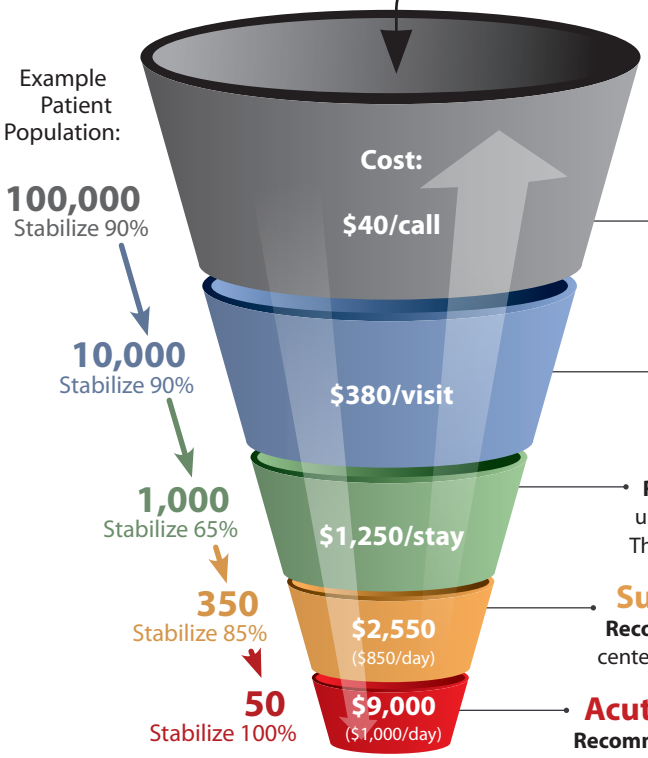


Reduces the stigma and discrimination surrounding mental health, the burden associated with seeking and treating mental health conditions, and increases an individual's ability to manage their mental wellness.

Treatment and interventions for individuals and families with the goal of reducing symptoms and increasing capacity to thrive in work, school, and relationships.

Crisis response and stabilization with the goal of preventing escalation and helping people achieve stability in order to enter treatment and manage their condition.

Helps people manage their mental wellness in the community. May extend beyond mental health care to services and supports that address "whole person" care and the social determinants of health.



Crisis Contact and Referral Center – 911 for behavioral health

Recommendation: Enhance the statewide crisis call center to serve as the centralized hub for coordinating behavioral health and crisis support services.

Mobile Crisis Outreach Teams (MCOT)

Recommendation: Extend 24/7 MCOTs across the entire state.

Short-term Observation and Stabilization

Recommendation: Create two or more community-based behavioral health urgent care centers that specialize in rapid assessment, evaluation, and stabilization. These centers will accept walk-ins and police drop-offs.

Subacute Hospitalization

Recommendation: Include subacute beds in the behavioral health urgent care centers & seek Medicaid mental health IMD waiver.

Acute Inpatient Hospitalization (Utah State Hospital)

Recommendation: Expand capacity at the Utah State Hospital.

Source: Utah Hospital Association. Based on visual representation of the Crisis Now Model developed by RI International. Sellar, J. (2018, January 25). Crisis System Optimization. RI International Consulting.

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.

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 (Figure 8).

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.

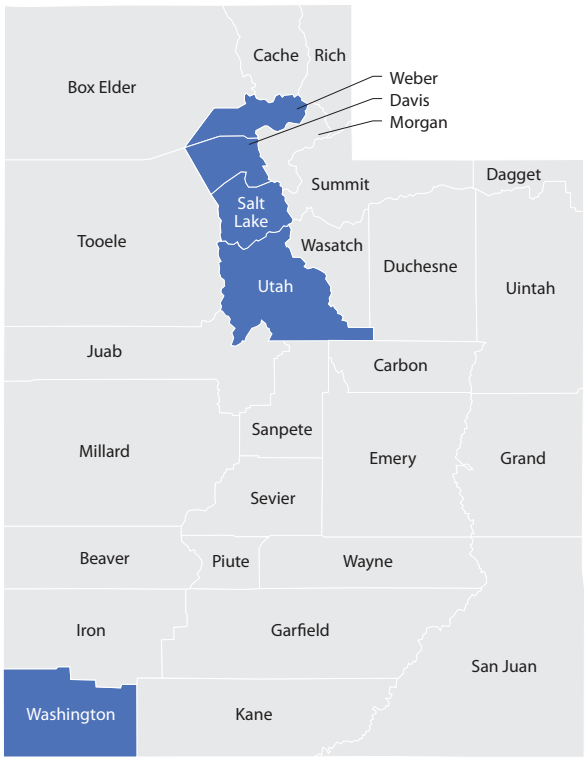
Figure 7: Utah's Current Crisis Call Center Volumes, FY2019

Program	FY19 Call Volume
SL County Crisis Line (801-587-3000)	40,310
SL County Warm Line (peer to peer)	21,325
National Suicide Prevention Lifeline - Utah Affiliate serving the entire state (1-800-273-talk)*	18,010
Total Calls	**79,645**

Calls to other local mental health authorities are in addition to this volume.

* Note: As of 1/1/19, this number is the Statewide Crisis line. As a result, volumes are significantly increasing.
Source: University Neuropsychiatric Institute - University of Utah Health.

Figure 8: Utah's MCOT Team Locations, 2019



Note: The University Neuropsychiatric Institute (UNI) operates MCOT teams in Salt Lake County. Other agencies provide MCOT services in other counties.
Source: University Neuropsychiatric Institute - University of Utah Health.

Building on the Success of Utah's Existing Access and Receiving Centers

Utah currently has several Access and Receiving Centers run by Intermountain Healthcare, the University of Utah, and local mental health authorities. These are "urgent care-like" facilities that are dedicated to behavioral health patients and provide:

- In-depth psychiatric evaluations
- 23-hour observation
- Referrals provided by crisis workers that help patients get into appropriate levels of care

Data show patient volumes have significantly increased at each of these centers over time. Data also show these centers are successful in diverting patients from the ER and lowering health care systems' costs.

More community-based behavioral health receiving centers are needed to keep up with growing demand, support system savings, and help people in behavioral health distress access appropriate care.

The newly developed behavioral health receiving centers (Tier I recommendation #10) will allow for police drop-offs, which will reduce ER volume and allow law enforcement to get back to patrol more quickly. The new centers will also allow for walk-ins (it is important to note that not all people in behavioral health distress go to the ER). These centers will help every person in the community who needs urgent behavioral health care.

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.

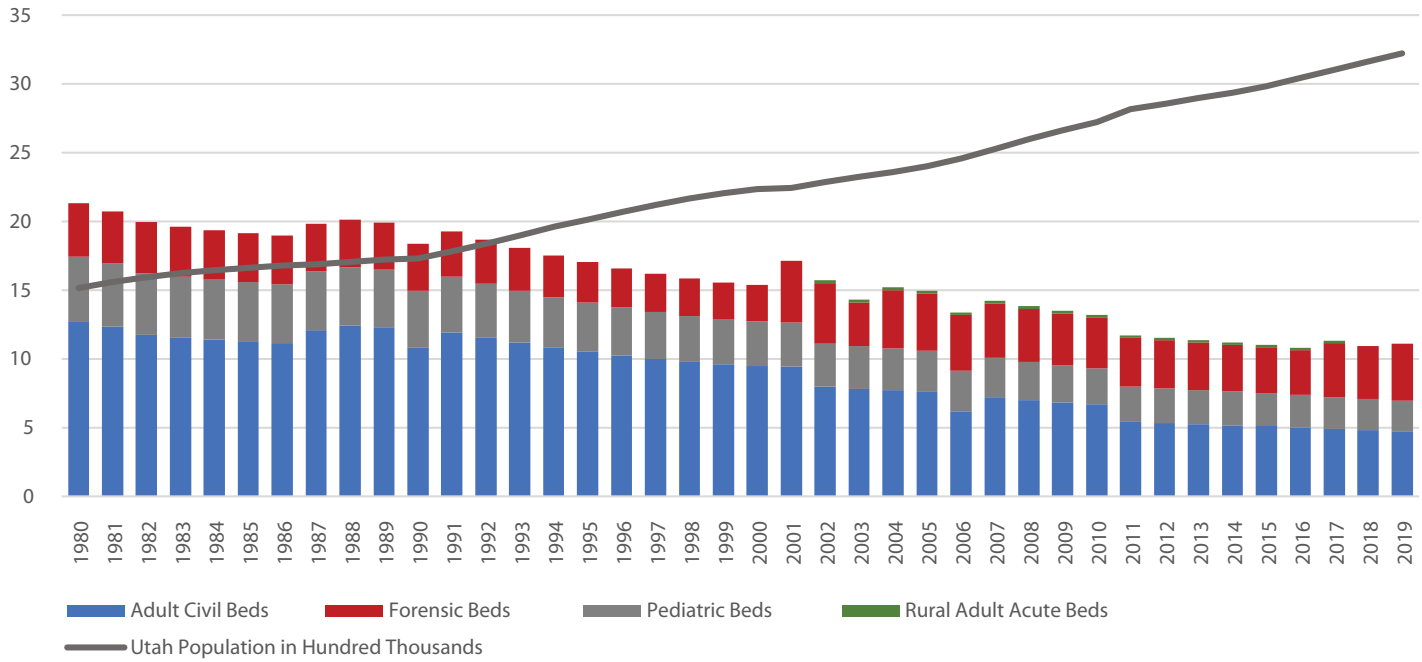
Acute/Inpatient Care

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 (Figure 9). 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.

Figure 9: Number of Utah State Hospital Beds per 100,000 People, 1980-2019



Source: Utah Department of Human Services.

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.

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.

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/.

Integrated Physical & Mental Health Care

3 Expand the Psychiatrist Consultation Program.

The Psychiatrist 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 Psychiatrist 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.

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 the Division of Substance Abuse and Mental Health (DSAMH) to implement evidence-based practice training and monitoring.

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.

TIER III

Promising solutions, but need further research to fully understand the impact.

Stabilization Supports and Wraparound Services

1 Develop a plan to expand Stabilization and Mobile Response (SMR) services to the rest of the state.

DSAMH, in collaboration with local mental health authorities, 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.

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.

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.

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 "wholeperson 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.
For more information, see Appendix 2.

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.

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.

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 Accountable Care Organizations (ACOs)), or moving to a consensus funding process.

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.

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.

A Future Focus on Pediatric Behavioral Health Services

UHA recognizes the importance of improving behavioral health services for specific populations such as children, seniors, and other targeted groups.

The need for more pediatric behavioral health services is particularly acute in Utah, given the growing number of children with behavioral health issues and the importance of early intervention for them and their families.

UHA supports an assessment of Utah's child and youth mental health systems to help inform future discussions and development of pediatric-focused recommendations.

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.

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.

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.

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.

TIER IV

Create structures to sustain behavioral health system improvements over time.

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., local mental health authorities, ACOs, behavioral health providers, researchers, and patients and community advocates).

2 Encourage state leaders to engage with Utah's federal representatives to support changes in federal behavioral health law.

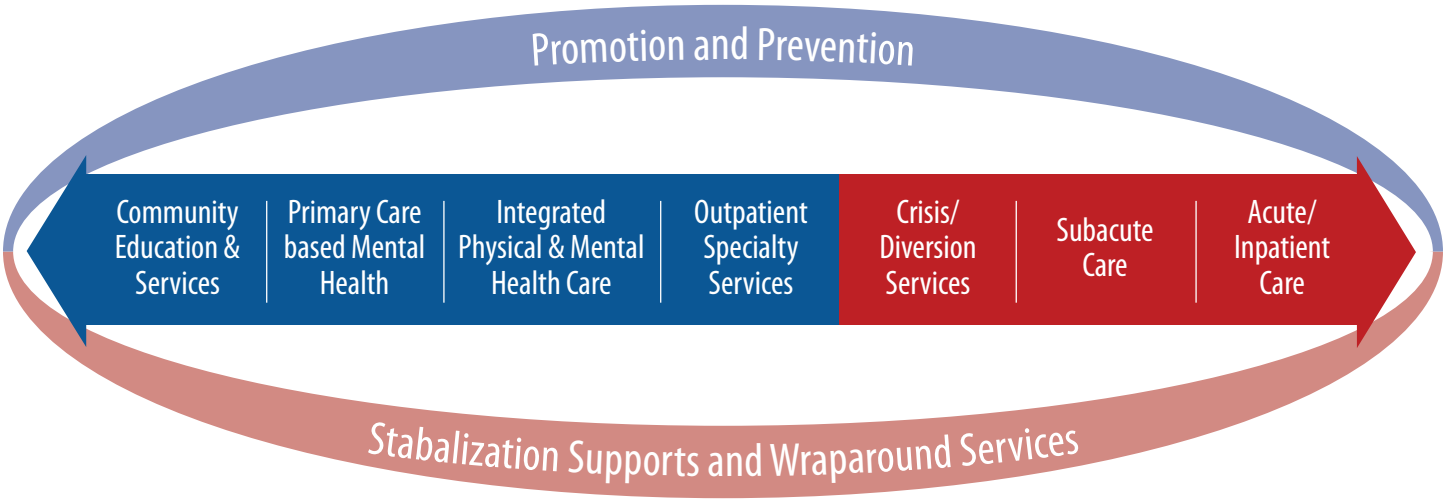
Topics could include, but are not limited to: (1) modernizing the information privacy requirements of 42 CFR Part 2, (2) addressing opioid use disorder providers' prescribing limits (physicians can only treat a limited number of patients), and (3) removing the Medicaid mental health IMD exclusion in its entirety.

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.

Appendix

Appendix 1: Utah's Continuum of Mental Health Care



Reduces the stigma and discrimination surrounding mental health, the burden associated with seeking and treating mental health conditions, and increases an individual's ability to manage their mental wellness.

Treatment and interventions for individuals and families with the goal of reducing symptoms and increasing capacity to thrive in work, school, and relationships.

Crisis response and stabilization with the goal of preventing escalation and helping people achieve stability in order to enter treatment and manage their condition.

Helps people manage their mental wellness in the community. May extend beyond mental health care to services and supports that address "whole person" care and the social determinants of health.

Promotion and Prevention: Education and awareness of mental health issues and services. Includes public education campaigns, mental health screenings, addressing lethal means such as firearm safety, etc. Goals are two-fold: (1) reduce the burden associated with mental disorders, and (2) increase an individual's control over their mental wellness.

Stabilization Supports or Wraparound Services: 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 social determinants of health. Examples include case managers, supportive housing, day treatment (e.g., clubhouses), employment assistance, transportation, building informal support systems, etc. Coordination of these services is critical and can be enhanced through digital connections, improved cross-system communication, and integrated services.

Community Education & Services: Mental health services provided in a community setting such as in schools, faith-based institutions, national and local suicide prevention hotlines, the SafeUT app, etc.

Primary Care Based Mental Health: Provision of mild to moderate mental health care in the primary care setting, which is often the first point of contact for patients with mental health needs. Primary care physicians are also the first line for delivering "whole person" care. 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.[12]

Integrated Physical Health and Mental Health Care: Integration of mental and physical health care provided in both physical and behavioral health care settings. Integration also helps address workforce shortages by better leveraging the existing workforce.

Outpatient Specialty Services: Mental health services provided by the licensed mental health workforce. Examples include APRNs, LCSWs, SSWSs, CMHCs, LMFTs, psychologists, and psychiatrists. Services are provided in an outpatient setting such as community mental health centers, offices, clinics, etc.

Crisis/Diversion Services: Services provided to help someone regain a sense of control and achieve stability to the point where they can enter treatment. These services also aim to prevent the escalation of mental health issues to the point where patients require subacute or acute inpatient care. Examples include mental health access centers, receiving centers, mobile crisis outreach teams, and crisis call centers. "The need for crisis services is not an inevitable consequence of mental disability, but rather the combined impact of factors that include a lack of essential services and supports, poverty, unstable housing, substance use, other health problems, and trauma." (SAMHSA)

Subacute Care: Subacute care is long-term services and supports provided in a non-hospital setting for people recovering from an acute mental illness or who need more targeted care. Examples include residential mental health facilities.

Acute/Inpatient Care: Inpatient mental health treatment and stabilization. Includes ensuring appropriate capacity at the Utah State Hospital.

Appendix 2: Integrated Care Models

A key gap in Utah's mental health system is the large-scale integration of physical and mental health care. Promoting integrated care models with targeted referrals to specialty mental health care is critical to improving access to mental health services as well as addressing workforce shortages.

Integrated care models are varied, and different approaches should be utilized based on each health system's needs. While some recommended approaches are provided in this report, UHA supports the continued use of existing integrated care models as well as the creative development of evidence-based, regionally appropriate models. This includes research that identifies: (1) current systems using integrated care or screening models that address "wholeperson 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. Examples of a few successful models that currently exist in Utah are provided below.

Intermountain Mental Health Integration (MHI) Model

The Intermountain Healthcare Mental Health Integration (MHI) model is a team-based, whole-person approach to meeting the physical and behavioral health care 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). Both Care Management and MHI Providers are embedded into primary care settings and work collaboratively within the care team, focusing their respective efforts on evidence-based brief interventions, team-member consultation and education, and establishing a clinic culture centered on treating the whole person.

Nearly 20 years after initial implementation, the Intermountain MHI model has proven to be a cost-saving approach to improving both clinical and operational outcomes. An evaluation published in the *Journal of the American Medical Association* (JAMA) found that the model resulted in a lower rate of ER visits, a lower rate of hospital admissions, and cost savings.[13]

Clinical improvements were identified in areas of depression screening/diagnosis, patient engagement in care self-management, and compliance/adherence to diabetes management. Financial improvements were realized via decreases in inappropriate care utilization rendered within costlier emergency and acute-care settings, coupled with more effective coordination of care delivery. The JAMA study also identified that an investment of $22 towards the team-based staffing structure—based on per member per year (PMPY) cost accounting—resulted in an overall system cost savings of $115 PMPY, demonstrating the value of this approach as part of a comprehensive population health management strategy.

Mountainlands Community Health Center / Wasatch Mental Health

Mountainlands Community Health Center, Inc., and Wasatch Mental Health have achieved physical and mental health integration through co-location and targeted referrals. Mountainlands is a federally qualified health center that provides medical, dental, mental health, and pharmacy services through a patient-centered medical home model.[14] Wasatch Mental Health is a comprehensive community mental health center that offers an array of mental health programs and services for children, teens, and adults, including inpatient

Barriers that restrict the use of integrated care include, but are not limited to:

- A lack of monetary incentives for providers to consult with other providers on client care, particularly with providers in different health systems, payer networks, or value-based contracts.
- A focus on providing and reimbursing acute and crisis care vs. preventive care and social supports.
- CPT codes and reimbursement rules that restrict behavioral health integration (e.g., same day billing, restrictions on Health and Behavior Assessment/ Intervention (HBAI) codes).
- Behavioral health workforce shortages and limited training opportunities.
- Restricted patient access to behavioral health services due to cost, a lack of commercial coverage, and transportation.
- Data sharing between medical and behavioral health providers and systems.
- Stigma and a lack of understanding of the importance of behavioral health from both patients and providers.

and residential care, day treatment, outpatient care, referral screenings, case management, and support services such as housing, transportation, employment, and rehabilitation services, among others.[15]

One of Mountainlands' health clinics is in the same office suite as Wasatch Mental Health therapists. In this suite, Wasatch therapists have direct access to Mountainlands clinicians, and Mountainlands clinicians have direct access to Wasatch therapists. Being co-located in the same office allows for immediate, targeted referrals, which results in timely, integrated physical and mental health care. Clients can move seamlessly from one office to the other without having to travel to a new clinic for physical or mental health needs.

As an example, one client scheduled a mental health intake at Wasatch Mental Health. The client was concerned about missing the appointment due to having sick children but brought the children to the appointment given the family's urgent mental health needs. The client verbalized distress about managing both the physical and mental health needs of the family. In response, Wasatch Mental Health scheduled an appointment with a Mountainlands clinician during the same visit. This allowed the family to complete their mental health intake as well as receive a medical checkup and necessary prescription medication without having to come back for a return appointment or travel to a different clinic.

Northeastern Counseling Center

Other community health centers in Utah use similar co-location and partnership models. For example, Northeastern Counseling Center (NCC), a community mental health center that serves Daggett, Duchesne, and Uintah Counties, has a therapist located in the same office suite as the Mountainlands Vernal clinic. NCC also hired a family practitioner and nurse practitioner to prescribe psychiatric medication as well as care for clients' basic health needs, including managing clients' other medications.

NCC has achieved successful physical and mental health integration through its case manager partnership model as well. NCC's case managers help clients schedule and attend medical appointments with physicians, as well as complete necessary follow up and address other physical health care needs.

University of Utah HOME Program

The Neurobehavioral HOME Program 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.[16] 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. Without the blending of funds, the clinic was underresourced and underfunded, which made the program unsustainable.[17]

The program currently operates as a health maintenance organization (HMO)[18] and receives capitated funding to provide physical and mental health services.[19] This promotes an integrated care model with co-located mental and physical health services, a shared electronic medical record, and care coordination.[20] Medicaid enrollees in the HOME program have access to all Medicaid services, which include annual physical exams and well-child checks, behavior management services, case management, crisis management, dietician/nutritional counseling, individual and group counseling, in-house billing and insurance support, medication management, primary medical care, preventive care, psychiatric evaluations, psychology services (testing), and specialty care referral.[21]

The program has been successful in keeping patients out of group homes and inpatient units, keeping patients at home with their families, and keeping patients out of the state developmental center.

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Our Goal

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.

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