Utah Behavioral Health Assessment & Master Plan

A guide for private and public sectors, systems, and stakeholders striving to create more accessible, equitable, aligned, and effective mental health and substance use disorder systems in Utah.

Version 1.0 | **January 2024**

Shared Vision

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

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The Utah Behavioral Health Coalition

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

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

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

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

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

3 Developing a Master Plan that can serve as a guide for private and public sectors, systems, and stakeholders striving to create more equitable, aligned, and effective behavioral health systems that provide timely access to person-centered and culturally responsive care through a comprehensive continuum of behavioral health services and supports.

The Behavioral Health Master Plan is a living document updated over time. This version outlines strategic priorities for behavioral health system reform, key questions, and recommended focus areas for programmatic changes. Future versions will identify specific objectives, actionable steps, and measurable outcomes for select priority areas. As the work begins and systems evolve, key questions and recommended focus areas may change, and more priorities, questions, and focus areas will be identified.

While some of the recommended programmatic changes may result in state-directed reform, the Master Plan is designed to call attention to high-priority areas and help facilitate solutions by other sectors and private systems. It does not intend to dictate or oversee all activities within or connected to Utah's behavioral health systems. That said, having a unified approach to system-level reform will help ensure all Utahns have better behavioral health.

*A unified approach to system-level reform will help
ensure all Utahns have better behavioral health.*

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

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Introduction

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

Access

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

The share of adults ages 18 or older with any mental illness (AMI) that received mental health services is 49.8% (2017–2019). This represents a 7.9 percentage point increase from 2008–2010, indicating an improvement in utilization. However, close to 50% of adults with AMI are still not receiving treatment.[4] A 2023 survey issued by the Office of Professional Licensure Review found Utah behavioral health providers report the average wait time at their primary practice locations is approximately 37 days, while the recommended guideline is 10 business days.

A limited number of rural, language accessible, and culturally responsive behavioral health providers limits access even more in Utah's rural areas and for Utahns from diverse cultures and communities.

58%

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

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

More than half of Americans say **mental health** is the **biggest health problem** facing our country.[5]

Workforce Shortages and Gaps in Care

Behavioral health needs in Utah currently outweigh the supply of services and supports. Utah has mental health provider shortages in every county and fewer mental health providers per 100,000 people than the national average.[6]

The COVID-19 pandemic amplified pressures on Utah's limited workforce, with mental health providers reporting a 20% median increase in caseloads since April 2020.[7] This is reflected in national numbers with nearly half of adults ages 18 or older with serious mental illness (SMI) noting that the COVID-19 pandemic negatively impacted their mental health.[8]

Numerous gaps in care exist across Utah's continuum of behavioral health services and supports[9] – in Utah's rural areas, for Utahns from diverse cultures and communities, as well as across the population lifespan (from infant and early childhood to older adults). Improving Utah's behavioral health systems requires expanding Utah's behavioral health workforce to address these gaps, particularly for individuals with crisis and complex behavioral health needs.

Utah's mental health providers reported a

20%

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

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

Need for System-Level Coordination and Innovation

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

An increasing number of siloed systems, such as self-pay (or cash-only) providers, further divides the system. This siloing creates challenges with equitable access, accountability, transparency, and monitoring the quality and efficacy of services. Some national studies estimate that only a portion of persons receiving behavioral health care benefit from treatment received.[10,11]

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

Benefit of Addressing Behavioral Health

Utah's experience is part of a national problem, where depression is estimated to cause 200 million lost workdays each year and SMI results in $193.2 billion in lost earnings.[12] Depression is a leading cause of disability nationwide[13] and national cost estimates of mental, emotional, and behavioral disorders among youth amount to $247 billion per year in mental health and health services, lost productivity, and crime.[14] This increases costs to public and private health systems and sectors such as education, corrections, the criminal legal system, housing, and child welfare.[15,16]

Investing in and improving access to high-quality behavioral health services can help reduce or neutralize costs across these public and private health systems and sectors.[17] More importantly, it saves lives.

Mental, emotional, and behavioral disorders among youth amount to

$247 billion

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

Key Findings from the Assessment

Assessment Process

Under the direction of the Utah Hospital Association (UHA) and the Utah Department of Health and Human Services (DHHS), the Kem C. Gardner Policy Institute and Leavitt Partners, a Health Management Associates company (LP/HMA), assisted the Utah Behavioral Health Coalition assess needs, gaps, and challenges in Utah's behavioral health systems. This assessment informed the development of the Behavioral Health Master Plan, which can serve as a guide for creating more accessible, equitable, aligned, and effective behavioral health systems in Utah.

As part of the assessment process, the Gardner Institute and LP/HMA conducted an environmental scan that included 30 formal discussion groups and in-depth interviews. [See "Discussion Group Details" text box for more information.]

The Gardner Institute also engaged in many informal interviews with additional groups interested in more targeted discussions about current initiatives and concerns. These discussions occurred through July 2023.

The Behavioral Health Coalition released a draft of the Behavioral Health Master Plan for public review and feedback at the end of July 2023. The coalition collected public feedback through the end of August and gathered additional feedback from presentations, discussions, and outreach through the beginning of November 2023. Version 1.0 of the Master Plan incorporates this feedback.

Discussion Group Details: Over 30 groups and 300 participants

30 discussion groups and in-depth interviews held from June 2022 to January 2023, as well as many additional informal discussions.

Over 300 participants engaged across discussion groups, interviews, and other feedback mechanisms.

Participants comprise a range of stakeholders involved in or connected to Utah's behavioral health systems, including representation from:

– Persons with lived experience (for example the Utah Behavioral Health Planning and Advisory Council (UBHPAC) and USAAV+ subcommittees)

– Community-based providers (local authorities, community health centers, federally qualified health centers, nonprofit and community-based providers, and others)

– Private behavioral health providers (behavioral health treatment providers, psychiatrists, residential and institutional providers, and others)

– Providers serving Utahns from diverse cultures and communities

– Service providers for persons who are unhoused

– Medical providers (pediatricians, family care practice physicians, clinical practitioners, and others)

– Payers (Utah's Medicaid Accountable Care Organizations (ACOs), the state's health insurance plan (PEHP), private health insurance companies, and high-deductible health plans)

– Providers of health promotion and prevention services (local and state coalitions, local authorities, and others)

– Crisis service providers

– Recovery and treatment supports (representatives from the recovery community and other nonprofit organizations)

– Health systems

– State agencies (representatives from the Department of Health and Human Services, Department of Workforce Services, Department of Insurance, the Utah State Board of Education (USBE), Department of Corrections, Utah State Courts, Utah's Attorney General's Office, and others)

– Legislators

– Education (both K-12 and higher education institutions)

– Court, criminal, and juvenile legal system representatives

– Employer representatives

System-Level Issues

An assessment of the information and feedback collected during the environmental scan indicates that five system-level issues are creating and exacerbating challenges in Utah's behavioral health systems (Figure 2). These system-level issues interconnect and impact access to services across Utah's continuum of behavioral health services and supports (Figure 1) for all persons across the population lifespan (from infants and young children to older adults).

The following section provides an overview of the system-level issues. Detailed findings from the environmental scan provide more information on the underlying gaps, challenges, and needs that contribute to these issues. [See "Environmental Scan: Detailed Findings" section for more information.]

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

Promotion and Prevention						
Community Education & Services	Primary Care Based Behavioral Health	Integrated Physical & Behavioral Health Care	Outpatient Specialty Services	Crisis/ Diversion Services	Subacute Care	Acute/ Inpatient Care
Stabilization Supports and Wraparound Services						
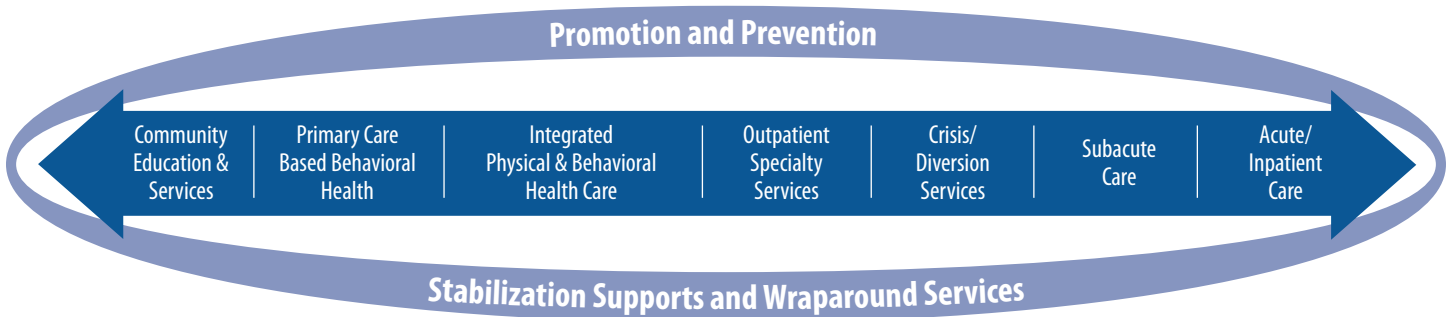
Note: This continuum was developed as a part of the 2020 Roadmap for Improving Utah's Behavioral Health System.
Source: Utah Hospital Association

Silver Linings

While the Master Plan primarily focuses on improvements to Utah's behavioral health systems, there are a lot of positives to recognize.

It is clear that:

- Utah's leaders, including the Governor and Legislature, understand the importance of addressing Utah's behavioral health needs.

- Utah's behavioral health providers are also passionate about addressing these needs.

- There is a growing number of sectors and stakeholders invested in improving Utahns' behavioral health, including employers.

- There is a desire to meet people where they are and provide services that are easily accessible.

- Utah is leading the nation on many behavioral health innovations and reforms (SafeUT, 988, Utah's comprehensive crisis system, supported employment, etc.).

- There are many examples of successful coordination at the local level that can be built on.

Figure 2: Utah's Behavioral Health System-Level Issues
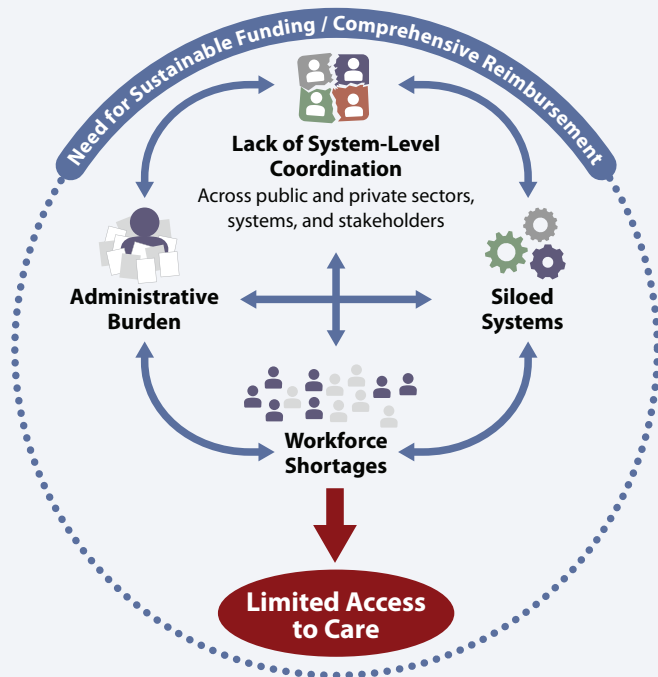
Source: Kem C. Gardner Policy Institute

Lack of system-level coordination across Utah's public and private sectors, systems, and stakeholders contributes to:

- **Increased administrative burden** for providers from managing multiple public- and private-sector contracts and grants (all with different reporting requirements).

- **Siloed approaches** to addressing behavioral health needs due to lack of awareness of existing efforts. Siloed approaches are also emerging as alternatives to administratively complex public and private systems, which leads to less coordination overall.

- **Exacerbated workforce shortages.** Siloed systems create new workforce demands that lead to shortages in other behavioral health systems. Administrative burdens also result in some behavioral health workers moving to less complex, but siloed systems (e.g., cash-only payment), while others leave the system altogether.

- **Low funding levels**, inadequate reimbursement, and having to navigate a complex patchwork of multiple funding streams intensifies all these problems.

- **Outcome:** These system-level issues result in delays or even an inability to access behavioral health services and supports and produce complex, often confusing systems for individuals seeking services.

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

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

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

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

- Different sectors, systems, and stakeholders connected to Utah's behavioral health systems.

- Different segments on the continuum of behavioral health services and supports.

- Different initiatives and groups working within each segment.

Lack of system-level coordination increases fragmentation and complexity of behavioral health care delivery. This creates challenges with transition support and patient navigation, which contributes to the state's access issues. The lack of coordinated systems also means public funds are not maximized for efficiency or effectiveness.

2 Administrative burdens

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

For example, one discussion group noted that some providers have up to twenty different behavioral health contracts with the state alone, all of which have different contract, reporting, and documentation requirements.

Other discussion groups noted the difficulty of having to navigate through multiple contracts and manuals to determine what services may be covered for a patient depending on the patient's eligibility (if in the public system) or health insurance plan (if in the private system).

Discussion groups also mentioned the time it takes to comply with audits and additional reviews in Utah's public behavioral health system as well as the administrative complexities associated with licensing, certification, and credentialing in both the private and public systems.

Discussion group participants suggested that these administrative burdens are resulting in workers leaving the state's public behavioral health system and that an increasing number of providers are also not paneling with private health insurance companies because of the complexity of credentialing and seeking reimbursement. This in turn complicates patient navigation and access.

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

3 Siloed systems

Having multiple, uncoordinated behavioral health administrative and service delivery systems contributes to well-intentioned but often siloed approaches to addressing Utah's behavioral health needs. Some of these initiatives stem from the desire to attend to specific behavioral health needs of certain populations, others develop because of lack of awareness of similar efforts already taking place, and others are emerging as alternatives to administratively complex public and private systems. However, when these efforts are developed or implemented without coordination or consideration of their impact on other behavioral health systems, they can result in inefficiencies, lost opportunities for broader positive impact, and possible unintended consequences. Some of the main concerns are that theses silos can:

- Create challenges with accountability, transparency, and monitoring the quality and efficacy of services.

- Are not always connected into other behavioral health systems (limiting referrals to other services and supports, limiting the ability to support transitions within the system, and complicating patient navigation).

- Duplicate services in already under-resourced systems.

- Exacerbate workforce shortages.

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

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

## Office of Professional Licensure Review: Behavioral Health Licensure Review

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

1. Utah has a behavioral health access problem, which may partially stem from workforce capacity issues. For example, while there are about 16,600 behavioral health practitioners actively licensed by the Utah Division of Professional Licensing (DOPL), some of these practitioners are not working in roles that require their license, are not working in the state of Utah, or are only working part time. In fact, 38% of practitioners surveyed by OPLR only work part time at their primary practice location. This translates to a behavioral health workforce of roughly 11,000 full time equivalents (FTEs).

2. OPLR also found that around 38% of behavioral health work hours are not spent in direct patient care, which further reduces the workforce.

3. According to a 2023 survey issued by OPLR, Utah behavioral health providers report that the average wait time at their primary practice location is approximately 37 days (the recommended guideline is 10 business days). Wait times for certain professions are even higher, with psychologists and behavior analysts reporting average wait times of ~64 days and ~131 days, respectively.

4. The proportion of practitioners accepting private health insurance is lower than the proportion of patients or consumers covered by private insurance—and self-pay providers appear to be filling this gap. Full self-pay is accepted by 60% of all behavioral health practitioners and 85-90% of independent practitioners surveyed by OPLR.

5. There are concerns with the quality and safety of Utah's behavioral health systems. Utah ranks poorly (40th relative to other states) on the number of National Practitioner Data Bank adverse action and malpractice claim reports per behavioral health worker (a key measure of safety for behavioral health).

4 Workforce shortages

Utah's ongoing—and growing—behavioral health workforce shortages disrupt care across the continuum of behavioral health services and supports. Workforce shortages impact all points along the service continuum, impact all areas of the state (Figure 3), and span all provider specialties. Some areas of particular concern are the limited number of rural, language accessible, and culturally responsive behavioral health providers as well as workforce shortages associated with outpatient care. Workforce shortages in outpatient care impact the ability to prevent a person's behavioral health issues from

Figure 3: Type of Mental Health Care Professional Shortage Area by County (Geographic, High Need, or Low Income), 2022
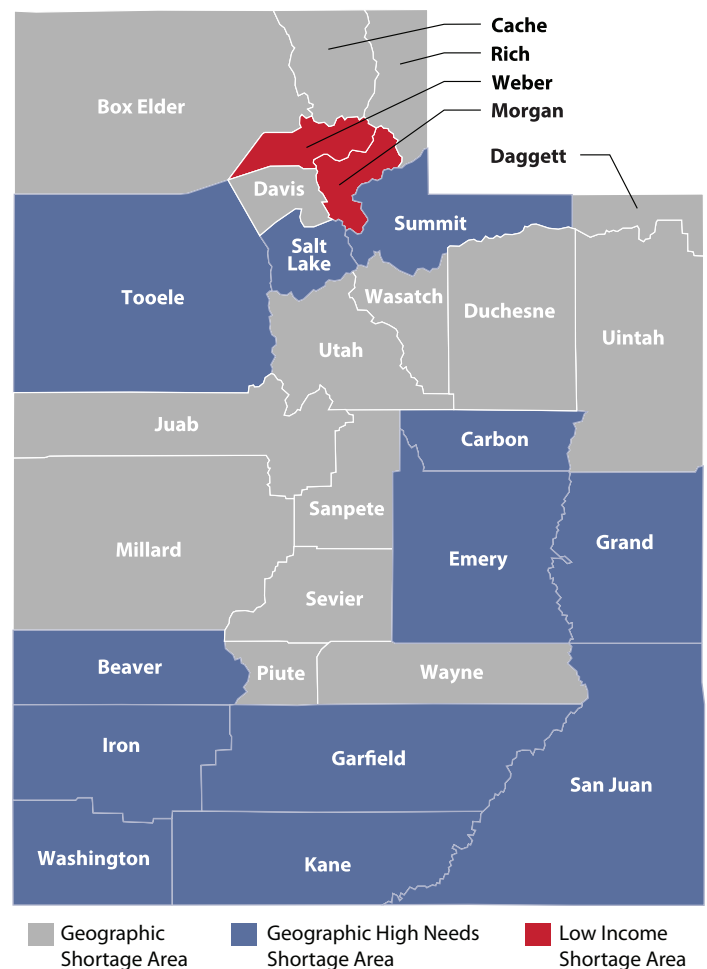
Mental health shortages are determined across three different domains. (1) Geographic, meaning there is a shortage of providers for the entire population within a defined geographic area. (2) Geographic High Needs, meaning at least 20% of the population has income below 100% FPL, there is a high ratio of children or elderly in the population, there is a high prevalence of alcoholism, or there is a high degree of substance use disorders. (3) Population groups, meaning there is a shortage of providers for specific population groups within a defined geographic area (e.g., low-income individuals). For more information on area definitions see Appendix I.
Source: Utah Office of Primary Care and Rural Health. Available from https://ruralhealth.health.utah.gov/workforce-development/primary-care-office-pco/shortage-designations/

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

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

Findings from the environmental scan also point to the need for (1) more provider education and training in evidence-based practices (e.g., engaging and training primary care providers in behavioral health screenings, early intervention, and treatment of mild-to-moderate behavioral health issues); and (2) more providers qualified to treat persons with co-occurring behavioral health and other conditions (e.g., unhoused, intellectual or developmental disabilities (ID/DD), and autism spectrum disorder).

Findings also highlight the need to expand the mental health and SUD workforce to include more certified or credentialed non-licensed professionals (e.g., peer support specialists,[18] certified case managers, community health workers or CHWs) as a solution to addressing Utah's workforce shortages.

5 Sustainable funding

Problems that arise from these system-level issues are intensified by low funding levels, inadequate reimbursement, a complex patchwork of multiple funding streams with different requirements, and high levels of administrative burden in seeking reimbursement. A common theme from the environmental scan is that many behavioral health services and supports in Utah lack long-term, sustainable funding.

As two examples, discussion group participants noted insufficient funding for prevention and early identification of behavioral health needs. Additionally, there is lack of reimbursement for stabilization supports and other wraparound services for individuals with more complex and long-term needs. Stakeholders also noted current rates do not allow systems and clinics to offer competitive wages, contributing to workforce shortages. Burdensome reimbursement requirements associated with supervision, documentation, service location, and utilization management further challenge the system.

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

Outcome: Limited access to care

As noted above, the lack of system-level coordination (multiple behavioral health administrative and service delivery systems, siloed systems, access points, etc.) produces complex, often confusing systems for individuals seeking services. As a result, people trying to access behavioral health services and supports often experience challenges with patient navigation and care transition support, which limits the ability to access the right care at the right place and at the right time. In addition, workforce shortages combined with increased demand for services results in delays or even an inability to access behavioral health services and supports.

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

Addressing the system-level issues described in this section could help alleviate pressures across the continuum of behavioral health services and supports, ensure demand is targeted to the right areas, improve issues with supply, and ultimately increase access.

Defining Access

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

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

Utah's Behavioral Health Master Plan

Mission of the Master Plan

Create equitable, aligned, and effective behavioral health systems that provide timely access to person-centered and culturally responsive care to all Utahns through a comprehensive continuum of behavioral health services and supports.

Framework

Utah's Behavioral Health Master Plan identifies strategic priorities and provides a roadmap for future reform. The Behavioral Health Coalition developed the Master Plan (Version 1.0) based on the findings from the environmental scan and behavioral health assessment. It utilizes a framework with four areas: (1) guiding principles; (2) strategic priorities; (3) key questions; and (4) focus areas (Figure 4).

Four principles guide current and continued development of the Master Plan. To help correct the system-level issues identified in the previous section and ensure an efficient system, Utah behavioral health system reforms should promote equity, alignment, value, and access.

Figure 4: Utah Behavioral Health Master Plan Framework

1	**Guiding Principles**	Guiding principles for system and programmatic changes.
2	**Strategic Priorities**	Strategic priorities for behavioral health system reform. Includes short and long-term initiatives.
3	**Key Questions**	Key questions to consider and areas that need further research to fully understand system impact.
4	**Focus Areas**	A set of recommended focus areas for programmatic changes with a now, next, and future timeline.

Source: Leavitt Partners, a Health Management Associates Company

Guiding Principles

Equity: Reforms should address behavioral health disparities and promote a state in which everyone has a fair and just opportunity to attain their highest level of health.[19]

A key part of equity is addressing "behavioral health disparities" or reducing behavioral health inequities and stigma and advancing diversity, inclusion, and access. [See "Addressing Behavioral Health Disparities" text box for more information.]

Alignment: Reforms should support coordinated, navigable, and sustainable behavioral health services across public and private systems, payers, and sectors.

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

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

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

Access: Reforms should increase access to person-centered, prompt, and affordable behavioral health services and supports to all Utahns across the population lifespan.

A key part of access is "person-centered" or designing reforms that promote and support people being active, engaged, and included in their treatment decisions. Person-centered access is responsive to the patient voice and considers individual, family, employer, community, and geographic need.

Equity | Value | Alignment | Access

Strategic Priorities

I	II	III	IV	V	VI	VII
Support continued use, implementation, creation, and innovation of evidence-based interventions.	Strengthen behavioral health prevention and early intervention.	Integrate physical and behavioral health.	Improve patient, family, and consumer navigation.	Continue to build out Utah's behavioral health crisis and stabilization systems.	Improve the availability of services and supports for individuals with SMI and complex behavioral health needs and their families.	Expand, support, and diversify Utah's behavioral health workforce.

The Master Plan's guiding principles directed the creation of seven strategic priorities. These priorities will be addressed concurrently and are designed to reflect community feedback, achieve the mission of the Master Plan, and improve behavioral health for all Utahns. The Master Plan also outlines key questions and recommended focus areas for future programmatic changes (a top-down and bottom-up approach).

It is important to consider this version as a starting point. Future versions will identify specific objectives, actionable steps, and measurable outcomes for select priority areas. As the work begins and systems evolve, key questions and recommended focus areas may change, and more priorities, questions, and focus areas will be identified.

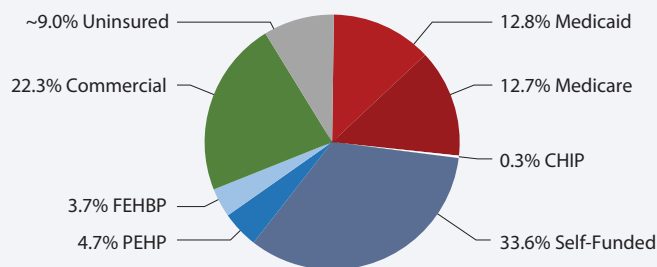It is also important to note that many key questions and recommended focus areas align with or support multiple strategic priorities, and could therefore be organized by topic, focus area, or segments within Utah's continuum of behavioral health services and supports (Figure 1). An example of how to organize the information by topic (payment reform) is in the "Organizing Utah's Behavioral Health Master Plan by Topic: Payment Reform" text box.

Finally, the Master Plan is designed to call attention to high-priority areas and help facilitate solutions by public and private sectors and systems. Involvement of the private sector is important given most people in Utah have employer-sponsored health insurance and access behavioral health services through private providers and systems (Figure 5, see "Utah's Health Care Coverage Landscape" text box for more information). A unified approach to system-level reform will help ensure all Utahns have better behavioral health.

Utah's Health Care Coverage Landscape

While Medicaid and the public health system are important payers of behavioral health services, most people in Utah have private health insurance coverage. The majority of Utahns receive health care coverage through their employers (~60%) and Utah has the highest rate of employer-sponsored insurance (ESI) in the country.[20]

Figure 5: Share of Utahns by Health Insurance Coverage Type, 2021

~9.0% Uninsured
12.8% Medicaid
22.3% Commercial
12.7% Medicare
0.3% CHIP
3.7% FEHBP
4.7% PEHP
33.6% Self-Funded

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

Commercial: Commercial health insurance is governed by state and federal law and regulated by state insurance departments. Plans are funded by premiums collected from insured employers and individuals.

Self-Funded: Employer-sponsored self-funded health plans are exempt from state regulation under the Federal ERISA statute and are regulated by the Federal Department of Labor. These plans may be funded entirely by the employer or by a combination of employer funds and covered employees' wages.

FEHBP: Federal Employee Health Benefit Plan is an employer-sponsored health insurance program for federal employees, retirees, former employees, family members, and former spouses.

PEHP: Public Employee Health Plan is an employer-sponsored health plan for public employees in the state of Utah.

CHIP: The Children's Health Insurance Program is a state health insurance plan for low-income uninsured Utah children and teens.

Addressing Behavioral Health Disparities

Needs Assessment

Health inequities, disparities, and stigma exist across Utah's entire continuum of behavioral health services and supports. A research team within the Utah Department of Health and Human Services (DHHS) conducted an assessment in 2022 that identifies needs and obstacles within Utah's mental health and SUD treatment systems that contribute to health disparities of four target populations (summarized here).[21] The report also includes a series of system, organizational, structural, and service-level recommendations.

The report's system-level recommendations are integrated in the Master Plan. The Master Plan also supports the adoption of the report's organizational, structural, and service-level recommendations as appropriate by private and public sectors, systems, and stakeholders looking to promote equitable access, reduce preventable health disparities, build systems that reduce structural barriers to care, and create more aligned and effective behavioral health systems in Utah.

Finally, the Behavioral Health Master Plan supports working with persons with lived experience and diverse stakeholders to identify specific objectives, actionable steps, and measurable outcomes for each area of the Master Plan.

Transition-Age Youth & Young Adults, Ages 14-26

Many transition-age youth are aging out of foster care or juvenile legal systems and are more likely to face suicide as a leading cause of death, have multiple chronic illnesses, and at least one chronic illness. This group often faces disparities in outcomes due to lack of collaboration between the child and adult systems to ensure seamless transitions of care, among other factors.

Black, Indigenous, and People of Color (BIPOC)

Research shows BIPOC have increased rates of mental health needs and SUDs including higher rates of depression, suicide ideation, race-related stress, and historical trauma and loss. Despite a higher need for care, BIPOC are less likely to receive care from providers even after requested. BIPOC may also experience discrimination in health care due to lack of providers who share identities with patients, as well as lack of provider education around stigma, among other factors.

LGBTQ+ Community

People in LGBTQ+ communities experience increased rates of behavioral health issues due to increased risk factors such as poverty, being unhoused, domestic violence, hate crimes, stigma, minority stress, and lack of social support, among other factors. They also experience reduced access to services and often face disparities in outcomes due to lack of LGBTQ+ specific knowledge and skill among providers and perceptions of marginalization and discrimination.

People with Developmental Disabilities

People with developmental disabilities face unique challenges that impact their need for mental health and SUD treatment, their ability to access treatment, and their treatment outcomes. Research shows people with developmental disabilities have increased rates of mental health needs including higher rates of anxiety, depression, obsessive compulsive disorder (OCD), suicide ideation, and adverse childhood experiences, among other mental health needs. This group also experiences reduced access to care and disparities in outcomes, which can be exacerbated by lack of knowledge about appropriate services, among other factors.
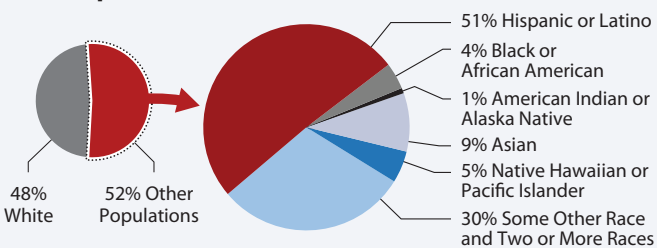
Diversity in Utah's Behavioral Health Workforce

Workforce shortages impact all areas of the behavioral health services and supports continuum, impact all areas of the state, and span all provider specialties. One area of particular concern, however, is the limited number of language accessible and culturally responsive behavioral health providers. For example, a study by the Utah Medical Education Council found White/Caucasian providers continue to make up a disproportionate share of Utah's mental health workforce compared to the overall population (although there have been some improvements as the proportion of White/Caucasian providers decreased from 92.5% to 88.5% between 2016 and 2021).[22]

As Utah's population grows and its demographics change (Figure 6) it is important for the state's behavioral health workforce to mirror and meet the needs of these diverse populations to ensure appropriate access for all Utahns.

Figure 6: Contributions to Utah Growth by Racial and Ethnic Populations, 2010 to 2020

- 48% White
- 52% Other Populations
- 51% Hispanic or Latino
- 4% Black or African American
- 1% American Indian or Alaska Native
- 9% Asian
- 5% Native Hawaiian or Pacific Islander
- 30% Some Other Race and Two or More Races

Source: Kem C. Gardner Policy Institute

Organizing Utah's Behavioral Health Master Plan by Topic: Payment Reform

Payment reform is a key component of Utah's Behavioral Health Master Plan. As noted above, low funding levels, inadequate reimbursement, and providers having to navigate a complex patchwork of multiple funding streams intensify Utah's system-level issues. Payment reform is necessary to ensure changes to Utah's behavioral health systems are sustainable and support the right level of payment for different markets and levels of care. Below are samples of key questions and recommended focus areas related to payment reform pulled from the seven strategic priorities.

Strategic Priority	Payment Reform		
	Reimbursement	**Value-Based Payments**	**Long-Term Sustainability**
Support continued use, implementation, creation, and innovation of evidence-based interventions.		Promote risk-based contracts and value-based payment arrangements (in both public and private systems) that incentivize and support innovation and outcome attainment.	How to create an infrastructure that supports providers access, utilize, and employ effective, evidence-based interventions across systems, sectors, and geographies (e.g., sufficient reimbursement and other forms of financial support for organizations that provide services to the uninsured/ underinsured)?
Strengthen behavioral health prevention and early intervention	Increase reimbursement for primary, secondary, and tertiary prevention services (e.g., behavioral health well-child visits and adult checkups). Ensure reimbursement for age-appropriate and uniform behavioral health screening across the lifespan (from infants and young children to older adults).		How to establish sustainable funding for a broad array of prevention services in both urban and rural geographies?
Integrate physical and behavioral health.	Allow providers to bill for physical health, mental health, and SUD services in the same day. Consider alternative payment models and ways to alleviate unnecessary cost-sharing. How to address reimbursement disparities between behavioral and physical health?	Incentivize system structures and payments for evidence-based integrated care approaches that address the physical and behavioral health of individuals and families. How to develop capitated payment models for different populations that include cost savings in and beyond behavioral health to reflect the entire medical cost?	What incentives, funding flows, or other efforts will help increase access to integrated physical and behavioral health care across Medicaid and other public and private markets to make it easier for individuals and families to access care earlier? How to improve parity for these services?
Continue to build out Utah's behavioral health crisis and stabilization systems	Expand private health insurance reimbursement of crisis services (receiving centers, mobile crisis outreach teams (MCOTs), etc.). Expand private health insurance reimbursement of evidence-based individual and family respite services and supports and other levels of care (psychosocial rehab, psychoeducation, etc.).	Promote bundled payments for crisis services that reflect regional needs.	

Improve the availability of services and supports for individuals with serious mental illness and complex behavioral health needs and their families.	Expand intensive outpatient options by adjusting reimbursement models to support sustainability. Ensure sustainable reimbursement for case management by Medicaid, private insurance, and with other funding for uninsured/underinsured populations. Create sustainable funding/reimbursement models that promote the development and expansion of community-based subacute programs and services (consider community-based models, crisis respite homes, individual, family, and crisis respite services, intermediate acuity care models, etc.). Create sustainable funding/reimbursement models for acute care services and residential care.	Promote bundled payments or global fees for episodes of care to improve reimbursement for community-based individual and family respite services and supports, club houses, recovery supports, supported employment/education, and other specialized services such as Coordinated Specialty Care (CSC) for psychosis prevention and early intervention.	What type of payment models or levels of reimbursement are necessary to develop, expand, and sustain community-based subacute services and programs for individuals with complex needs? How to create and promote sustainable reimbursement structures in public and private markets that reflect risk, costs, regional differences, and the complexity of care? Should public and private markets establish differentiated rates based on risk and outcomes that are appropriate for the population served? How to create sustainable funding for addiction recovery services? Determine effective ways to help sustain community-based organizations that provide behavioral health and other safety net and supportive services to the uninsured/underinsured. Funding should be equitable, flexible, and sustained over time.
Expand, support, and diversify Utah's behavioral health workforce.	**Certified or credentialed non-licensed professionals**		
	Establish Medicaid reimbursement for community health workers (develop state plan language that is broad enough to encompass behavioral health issues and referral supports). Expand reimbursement of research-supported recovery-based models that rely on non-licensed professionals such as peer supports, case managers, etc.	Promote use of bundled payments that reflect regional needs to improve reimbursement for peer supports, CHWs, case management, etc.	What levels of reimbursement, grants, and additional resources are needed to expand peer supports, case managers, CHWs, and other non-licensed care team members? How to equitably distribute these resources to community-based and nonprofit organizations? Determine effective ways to help sustain community-based organizations that support peer support specialists and other non-licensed providers. Funding should be equitable, flexible, and sustained over time.
	Other		
	Maintain advancements made to telehealth during the COVID-19 Public Health Emergency (PHE), including ensuring meaningful and equitable reimbursement.		Determine effective ways to help sustain culturally responsive and language accessible behavioral health providers to meet the needs of Utah's changing demographics. Funding should be equitable, flexible, and sustained over time.

Strategic Priorities: Steps to System Reform

I **Support continued use, implementation, creation, and innovation of evidence-based interventions.**

Environmental scan discussion group participants feel that messaging around mental health and SUDs needs to focus more on behavioral health conditions being treatable and that "recovery is possible." Having access to high-quality and evidence-based services, supports, and interventions can help people achieve recovery.

According to the Institute of Medicine, quality health care is "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[23]

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

➡ NOW

Key Questions

- What is the role of regulatory agencies in overseeing the use of evidence-based treatments/interventions and monitoring patient outcomes? How will the use of evidence-based interventions be continuously evaluated to make necessary adjustments based on the outcomes? What resources do these regulatory agencies need to accomplish proposed changes to their roles?

- What role does accreditation play in ensuring the use of evidence-based interventions that reflect the needs of populations being served (e.g., urban vs. rural)?

- How to improve collaboration with higher education, program evaluators, implementation science researchers, training and certification programs, public

and private health systems, and payers in identifying and promoting the use of evidence-based interventions?

- Should the state consider the development of an intermediary organization (or expand the duties of the existing behavioral health licensing board) to evaluate outcome measures and support system-wide adoption of evidence-based practices and a standardized set of quality measures?

Focus Areas

- Increase the use of valid measures that provide transparency into outcomes (Outcome Questionnaire, Functional Outcome Survey, Brief Addiction Monitor, Substance Use Recovery Evaluator (SURE),[24] etc.).

- Promote internal processes for evaluating if changes in care, treatment, or access could help prevent instances of suicide.

- Support research that reflects the patient voice and contributes to the development of assessments, evaluation tools, and evidence-based practices by and for populations with lived experience and from diverse cultures and communities.

➡ NEXT

Key Questions

- How to create an equitable structure that increases transparency, helps identify behavioral health disparities, and holds public and private providers accountable for the effectiveness of appropriate services delivered to different populations in different sectors and geographies?

- How to create an infrastructure that supports providers access, utilize, and employ effective, evidence-based interventions across systems, sectors, and geographies (training, accountability structures, accreditation, sufficient reimbursement and other forms of financial support for organizations that provide services to the uninsured/underinsured, etc.)?

Focus Areas

- Use science-based definitions of evidence to inform effective treatments and interventions.

- Develop common methodologies or frameworks for reporting outcomes and performance data across public and private systems and sectors to:

  Increase transparency; and

  Hold public and private providers accountable for the effectiveness of appropriate services delivered to different populations in different sectors and geographies.

- Promote risk-based contracts and value-based payment arrangements (in both public and private systems) that incentivize and support innovation and outcome attainment.

➡ FUTURE

Key Questions

- How best to financially support and sustain behavioral health innovation and the development and implementation of evidence-based interventions over time?

- How to demonstrate that cost savings from addressing behavioral health impact the entire health ecosystem, and ensure these dollars are effectively reinvested back into behavioral health? (i.e., how to account for cross-sector savings from addressing behavioral health?)

Focus Areas

- Promote existing research, projects, and new initiatives across private and public payers, systems, and sectors that demonstrate overall medical, educational, and social service cost savings to ensure sustainability.

II Strengthen behavioral health prevention and early intervention.

Effective promotion, prevention, and early intervention—starting in childhood—is critical to getting ahead of Utah's growing behavioral health needs, reducing stigma around mental health and SUDs, and building resiliency and emotional flexibility. It positively impacts children, parents, families, schools, and communities, which can in turn bolster protective factors, reduce risk factors, and increase individual- and societal-level productivity and well-being.

Preventing or delaying the escalation of worsening behavioral health issues also reduces the need for more acute and costly services, which places downward pressure on public and private system costs and reduces costs in other sectors such as education, corrections, the criminal legal system, housing, and child welfare. The Master Plan supports strategies that promote effective, coordinated, and community-based prevention and early intervention strategies.

"We need effective upstream strategies."

➡ NOW

Focus Areas

- Continue to provide mental health and SUD training and technical assistance to families, communities, providers, and other system stakeholders across the state, including but not limited to:

  Childcare and preschool providers: (e.g., The Children Center Utah's Infant and Early Childhood Mental Health Training and Teleconsultation Program).

  School counselors and other K-12 staff: (e.g., the Utah School Mental Health Collaborative's school district technical assistance and training[25]). Training could include education on the roles/responsibilities of school counselors, school-based mental health professionals, and information on how to connect with community mental health providers. See "Environmental Scan: Detailed Findings" section for more information on these points.

  Law enforcement: Training could include education about mental health and SUD episodes and how to interact with individuals with cognitive impairment and high behavioral health needs (e.g., individuals who cycle through the criminal legal system, homeless shelters, and emergency departments).

- Improve alignment and sustainability of current programs that help prevent, intervene early, and coordinate efforts to support and address the mental health needs of Utah's most vulnerable child and youth populations in the context of the family (including children served by the Division of Child and Family Services, DCFS). Examples include the Utah Infant Toddler Court Program, Systems of Care, stabilization and mobile response teams, Family Peer Support Specialists, etc.

- Continue to support schools and other community-based settings by making behavioral health programming available that focuses on normalizing behavioral health discussions, SUD prevention, and mental health promotion and resilience.[26]

- Leverage the work currently being completed by the Utah Early Childhood Mental Health Working Group to expand awareness of prevention and early intervention services that can be reimbursed by public and potentially private payers (well-child visits focused on mental health, Early and Periodic Screening, Diagnostic and Treatment (EPSDT); DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; Screening, Brief Intervention and Referral to Treatment (SBIRT), etc.). [See "Meeting the Mental Health Needs of our Infants, Children and Youth" text box for more information.] Consider ways to develop similar reimbursement guides for schools, preschools, and other community or non-clinical settings.

- Continue to facilitate and support engagement around eliminating stigma—aligning efforts with the Huntsman Mental Health Institute (HMHI) anti-stigma campaign (where appropriate) to identify and address structural stigma (laws, regulations, policies), public stigma (attitudes, believes, behaviors), and self-stigma (internalized negative stereotypes). Examples are below.

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

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

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

NEXT

Key Questions

- How to better integrate prevention into Utah's continuum of behavioral health services and supports?

- How to establish sustainable funding for a broad array of prevention services in both urban and rural geographies?

- How to better understand and address the underlying issues that contribute to risk factors for mental health and SUDs and improve coordination among Utah's existing prevention systems. Better alignment among groups addressing similar risk and prevention factors could help create more efficiencies within systems.

Focus Areas

- Explore how research and models that support positive childhood experiences and strengthen protective factors can be expanded or adopted across Utah's behavioral health systems to counter the impact of adverse childhood experiences (ACEs) for all Utahns (with a specific focus on models developed by and for Utahns from diverse cultures and communities).

- Evaluate ways to expand and improve the provision of family-based care for children, youth, and adults (use of available codes, effective models, individual and family respite services and supports, services and resources for families assisting persons with suicide ideation, etc.).

- Build systems that promote appropriate screening and identification of need with referral to indicated interventions with a primary focus on screening for children.

- Increase funding for primary, secondary, and tertiary prevention services, including reimbursement by public and private payers (e.g., sustainable reimbursement for behavioral health well-child visits and adult checkups).

FUTURE

Focus Areas

- Ensure access to, and reimbursement for, age-appropriate and uniform behavioral health screening across the lifespan (from infants and young children to older adults). This could also support baseline data creation and monitor changes in need.

Meeting the Mental Health Needs of our Infants, Children, and Youth

There is a need for infant, child, and youth mental health services in Utah. National research shows Utah is among a group of states with the highest prevalence of child and adolescent mental health disorders and the highest prevalence of youth with untreated mental health needs.[27]

Early investment improves children's current and future health. Research shows a link between unmet mental health needs in a child's earliest years and their lifetime outcomes.

To develop strategies and tactics to strengthen and improve early childhood mental health in Utah, the Children's Center Utah assembled the Utah Early Childhood Mental Health Working Group in 2021. The working group consists of stakeholders from a variety of early childhood-related professions and backgrounds.

The group is currently working on efforts to:

1. Create a baseline estimate of need for early childhood mental health services.

2. Increase integration of physical and behavioral health for children by examining financing policies to address early childhood mental health needs before they escalate to the point of functional impairment (e.g., expanding awareness of prevention and early intervention services that can be reimbursed by public and private payers).

3. Increase early childhood mental health awareness.

Integrate physical and behavioral health.

Improving Utah's behavioral health systems requires more focus on integrating physical and behavioral health across and within public and private clinics, systems, and payers. Promoting integrated care models and coordinated referrals to behavioral health care expands access to mental health and SUD services, reduces stigma, and helps to alleviate workforce shortages.

Research shows integrated approaches address system fragmentation and close care gaps, improve care management, provide a holistic member experience, and are generally cost effective. For example, overall spending on individuals with a behavioral health diagnosis is 2-4 times higher than for individuals without a behavioral health diagnosis.[28] Improving integration between physical and behavioral health care can help reduce these costs.[29,30]

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

- Expand existing primary care integration models and increase coordination between primary care and behavioral health providers.

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

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

Expand existing primary care integration models and increase coordination between primary care and behavioral health providers.

Improved detection, effective management, and recovery of mild-to-moderate behavioral health conditions through increased coordination between primary care and behavioral health can help prevent behavioral health needs from worsening and alleviate pressure on downstream services and supports. Research shows 10–20% of the general population will consult a primary care clinician for a mental health need in a given year, and that 10–40% of primary care patients have a diagnosable mental disorder.[31]

Primary care integration and coordination is growing in Utah, and the Master Plan supports strategies that continue to increase integration and coordination between primary care and behavioral health providers. This includes supporting existing, evidence-based primary care integration models; creating regionally based referral networks to support primary care providers with clear pathways to community-based outpatient and specialty behavioral health providers; as well as

leveraging certified or credentialed non-licensed professionals (peer support specialists, certified case managers, CHWs, etc.) as integrated care team members to help build the bridge between primary care and behavioral health providers (see strategic priority #7).

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

➡ NOW

Focus Areas

- Continue to expand statewide consultation support to primary care providers (e.g., Psychiatric Consultation Program, or CALL-UP).

- Provide education, training, centralized support, resources, and technical assistance to pediatric, family, and primary care providers across the state to invest in the Collaborative Care Model.

- Allow providers to bill for physical health, mental health, and SUD services in the same day. Consider alternative payment models and ways to alleviate unnecessary cost-sharing.

- Ensure individuals with alcohol, opioid, and other SUDs have access to primary-care based SBIRT, Medication Assisted Treatment, Office-Based Opioid Treatment, and harm reduction approaches such as naloxone. Focus on eliminating gaps in these services for Utahns from diverse cultures and communities. [See "Total Drug Fatalities in Utah" text box for more information on current trends.]

- Improve integration of tobacco cessation programs in mental health and SUD treatment and provide tobacco cessation training to the behavioral health workforce.

➡ NEXT

Focus Areas

- Improve the availability of integrated physical and behavioral health services for populations at the beginning and end of the lifespan (infant and early childhood, youth ages 6-12, and the geriatric population) by supporting and sustaining successful, evidence-based primary care integration models and expanding training and technical assistance across the state to pediatricians, other licensed clinicians, and physicians treating the aging population. [See "Increasing demand for Behavioral Health Services among Utah's Aging Population" text box for more information on the behavioral health needs of Utah's aging population.]

- Foster systemic connections between primary care providers, outpatient behavioral health providers, and school-based mental health professionals (e.g., encourage primary care providers, local authorities, other community behavioral health providers, and schools to align care needs and create referral pathways for patients to access a comprehensive continuum of behavioral health services and supports).

- Where appropriate, promote training on brief physical health interventions and therapies for behavioral health providers working in integrated settings.

Total Drug Fatalities in Utah

Total drug-related fatalities in Utah increased in 2020-2021 (Figure 7); however, preliminary data from 2022 show a slight decrease. The main drivers of the 2020-2021 increase were fentanyl and methamphetamine, which was the most common drug involved in fatal overdoses. Deaths from prescription opioids and heroin slightly decreased.[32]

Utah's methamphetamine involved deaths increased nearly 2.5 times from 5.6 per 100,000 adult population in 2015 to 12.2 in 2021.[33] American Indian/Alaska Native populations have the highest fatal drug overdose rates followed by Black or African Americans.[34]

Figure 7: Total Drug-Related Fatalities in Utah and the U.S., 2011-2020
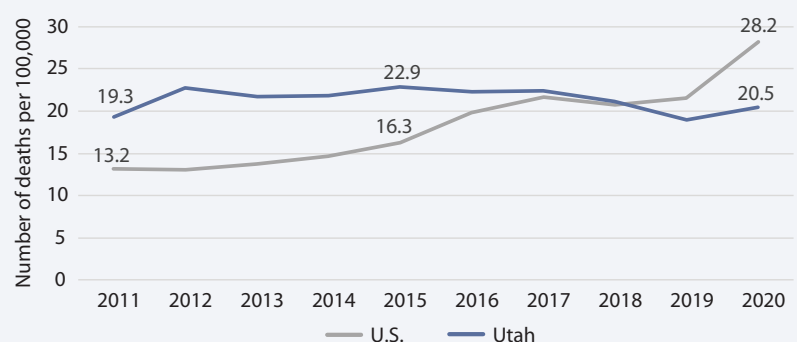
Note: Total drug-related fatalities include those coded as unintentional, suicide, homicide, or undetermined intent.
Source: Utah Department of Health and Human Services, Indicator-Based Information System for Public Health.

Increasing demand for Behavioral Health Services among Utah's Aging Population

Utah's average age remains the youngest in the nation, but the state has one of the fastest growing per capita populations of adults age 65+. Projections indicate that Utah's older population (ages 65+) will more than triple over the next several decades—from 376,000 people in 2020 to 1.2 million in 2060—which is shifting demand for behavioral health services to older adults.[35]

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

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

The Utah Commission on Aging (UCOA) is in the process of developing a Master Plan on Aging that will more comprehensively identify and address the behavioral health needs of older adults among other issues such as preventive care, services for persons who are unhoused or have disabilities, family caregiving, etc. This plan should be complete in November 2023.

"The excess annual adjusted health care costs of depression, anxiety, and comorbid depression and anxiety reached $27.4, $80.0, and $119.8 million per 1,000,000 elderly population, respectively." [36]

➡ FUTURE

Key Questions

- How to expand and support effective integrated care models utilized in behavioral health outpatient services that create direct linkages back to primary care?

- How to expand integrated care models across the continuum of behavioral health services and supports beyond primary care?

Focus Areas

- Develop enhanced, regionally based referral networks to support pediatricians and primary care providers with screening, early identification, and connecting to behavioral health providers.

- Incentivize system structures and payments for evidence-based integrated care approaches that address the physical and behavioral health of individuals and families.[37]

- Partner with populations with lived experienced and from diverse cultures and communities to evaluate gaps in behavioral health programs (across all populations, communities, and geographies). Determine what evidence-based programs, digital tools, and other services could be expanded, supported, developed, and coordinated to promote behavioral health, wellness, and the management of mild-to-moderate behavioral health needs.

- Work with Utah's medical schools to incorporate more training and education on mental health and SUDs in their programs.

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

The Master Plan supports evaluating ways to reduce barriers in delivery of services across and within the state's public physical and behavioral health systems.[38] This could include evaluating Medicaid beneficiaries' access to and choice of behavioral health providers as well as any gaps that may exist based on Utah's changing behavioral health needs and services.

Any proposed policy and program changes should account for the high-acuity services the counties provide to the SMI, uninsured, and underinsured populations. Proposed changes should also consider the counties' safety net behavioral health funding, the value of their community-based and region-specific

systems, their cross-sector connections and partnerships, and the critical wraparound services and supports they provide. [See "Utah's Uninsured and Underinsured Populations" text box for more information on the need to maintain a focus on uninsured and underinsured populations.]

⮕ NOW

Key Questions

- How to streamline the roles of state regulatory agencies to reduce unnecessary administrative complexities for public providers?

- What are the roles and responsibilities of state and county government with respect to delivering behavioral health services, providing access to care, reducing suicide and overdose deaths, etc. as currently provided and as outlined in Utah Code?[39]

- How to streamline Medicaid benefits and plan options? How to simplify plan options within Medicaid to reduce disruption when Medicaid members have eligibility changes?

- How to improve continuity of care in Medicaid? (e.g., establish 12-month continuous eligibility for adults in Medicaid to prevent people from switching programs more than necessary)

- How to improve Medicaid beneficiaries' choice of providers and services (especially in rural areas and by diverse cultures and communities)? Evaluate network adequacy or the 1915(b) freedom of choice waiver?

- How to define network adequacy? How does network adequacy differ in Utah's rural and frontier areas? How to ensure these areas have adequate access to equitable, culturally responsive, language accessible, and nondiscriminatory services that reflect patient voice?

- How to improve standardization of services and accountability among Utah's local authorities?

Focus Areas

- Convene county officials, ACOs, community-based providers, nonprofit organizations, patients/consumers (including from rural areas and diverse cultures and communities), and other relevant groups to discuss and determine appropriate integrated delivery models for different areas. These conversations should account for current challenges associated with the Utah Medicaid Integrated Care (UMIC) program (see Environmental Scan: Detailed Findings" section for more information).

Models could include Primary Care Behavioral Health, Collaborative Care, integrated accountable care organizations, or integrated behavioral health care programs.[40]

- Harmonize performance metrics and reporting requirements across Medicaid and the Office of Substance Use and Mental Health (SUMH).

- Simplify and streamline behavioral health related billing, coding, reporting, and other administrative requirements across Medicaid's ACOs.

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

While it is important to address the integration of physical and behavioral health within Utah's public health systems, only a fraction of Utah's population qualify for public services. Most Utahns have employer-sponsored health insurance and access behavioral health services through private providers and systems (Figure 5).

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

⮕ NEXT

Key Questions

- How to streamline current behavioral health regulations and administrative requirements across public and private payers and systems to reduce unnecessary administrative complexity for behavioral health providers and consumers?

- How to address the movement of behavioral health providers from the public/private market to the self-pay or cash-only market (address administrative burdens, incentivize providers to participate on insurance panels, reduce barriers to participating in Medicaid, etc.)?

- What incentives, funding flows, or other efforts will help increase access to integrated physical and behavioral health care across Medicaid and other public and private markets to make it easier for individuals and families to access care earlier in the continuum of behavioral health services and supports? How to improve parity for these services?
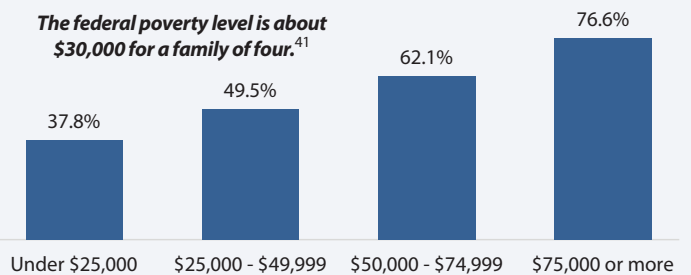
Utah's Uninsured and Underinsured Populations

The Master Plan supports ensuring comprehensive and sustainable behavioral health services for Utah's uninsured and underinsured populations, while simultaneously seeking to improve coverage and payment parity. This includes determining effective ways to help sustain the local authorities and other community-based organizations that provide behavioral health and safety net services to uninsured and underinsured Utahns. Funding should be equitable, flexible, and sustained over time. If Utah's uninsured and underinsured residents are unable to access appropriate care in lower acuity settings, their behavioral health conditions may worsen leading them to seek services in emergency departments, hospitals, and other high-cost settings.

About 9% of Utah's population is uninsured (Figure 5), which translates to just over 300,000 individuals. While Utah expanded Medicaid coverage in 2020 to Utah adults with annual income up to 138% of the federal poverty level (FPL), it is important to recognize that segments of Utah's population remain ineligible for Medicaid, earn too much to qualify for Medicaid and cannot afford marketplace plans or other private insurance, or are uninsured for a variety of other reasons.

The high-cost and limited coverage of some mental health and SUD services, coupled with a growing number of Utahns with high-deductible health plans (HDHPs), also means many families could be underinsured when it comes to behavioral health. [See "High-Deductible Health Plans" text box for more information.] Close to 40% of Utahns with family income below $25,000, and 50% of Utahns with incomes between $25,000-$49,999, have employer-sponsored health insurance (Figure 8). Individuals with private health insurance who run into coverage limits or need additional services they cannot afford may end up in the crisis system and then the public system to receive necessary care. This makes Utah's publicly funded behavioral health system the de facto payer of behavioral health services. Alternatively, when people move off Medicaid due to increases in their income, they often lose access to a broad array of services and potentially their behavioral health home. Discussion groups feel more funding is needed to support Utah's low-income populations and the safety net providers that serve them.

Figure 8: Share of Utahns by Family Income Level Covered by Employer Sponsored Health Insurance, 2021

The federal poverty level is about $30,000 for a family of four.[41]

Under $25,000	$25,000 - $49,999	$50,000 - $74,999	$75,000 or more
37.8%	49.5%	62.1%	76.6%

Notes: A primary source of coverage was assigned for respondents selecting multiple sources of coverage.
Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, 2021.

Focus Areas

- Improve awareness and use of available behavioral health related codes across public and private payers.

- Simplify and streamline state licensing, certification, and provider credentialing.

- Begin to engage with private payers, employers with self-funded health plans, self-pay providers, and other direct-to-consumer market entities (Employee Assistance Programs (EAP), online mental health/counseling platforms, etc.) to create a shared vision for coordinated systems. [See "An Unknown: The Impact of a Growing Direct-to-Consumer Market" text box for more information.]

➡ FUTURE

Key Questions

- What are the roles and responsibilities of public and private behavioral health providers, including self-pay providers?

- How to create equitable access to behavioral health benefits for an increasing number of patients and consumers with HDHPs and employer-sponsored self-funded plans? [See "High-Deductible Health Plans" text box for more information.]

- Are there essential behavioral health services that private health insurance plans should be responsible for covering?

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

The already growing market for direct-to-consumer and digital mental health services expanded during the COVID-19 pandemic.[42] These online services and digital tools help create access and can be effective options for individuals with mild-to-moderate mental health needs.

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

Direct-to-Consumer Market →

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

Employer and employee education around how to effectively use HDHPs will be important as the number of Utahns covered by HDHPs grows. HSA-qualified HDHPs accounted for 40.1% of Utah's comprehensive health insurance market in 2021, compared with only 3.0% in 2007.[43] These plans have lower monthly premiums, but the higher deductibles require individuals and families to pay more out-of-pocket costs before their insurance plan begins to cover expenses. Today, HSA-qualified high-deductible family health plans have a minimum deductible of $3,000 with a maximum of $15,000 in out-of-pocket expenses.[44] This means families enrolled in these plans are responsible for paying $3,000 of their covered health care expenses (or more if the deductible is higher) before the insurance company begins to pay a portion of the costs.

While HDHPs may save individuals and families money in the short run through lower monthly premiums, they can deter some individuals from seeking appropriate medical care because of the higher, upfront out-of-pocket costs.[45]

More than half (63%) of Utahns report delaying or going without health care due to cost. Almost a third of this group reports problems accessing mental health services or addiction treatment due to cost. The rate is higher for respondents of color and the Hispanic/Latino population.[46]

3% 2007 **High-Deductible Health Plans** **40%** 2021 →

- How to improve patient and consumer access and choice across private payers and systems?
- How to develop capitated payment models for different populations that include cost savings in and beyond behavioral health to reflect the entire medical cost?
- How to attribute costs to the appropriate payer (both public and private) and avoid cost shifting from the private to the public market?
- How to address reimbursement disparities between behavioral and physical health? How to better align payment parity between physical and behavioral health providers with similar level of education and training to ensure sustainability and ease the relative cost of administrative burdens?
- What type of structure needs to be in place to help align and enforce parity across these different markets? [See "Proposed Amendments and Updates to Mental Health Parity Rule" text box for more information.]

Focus Areas

- Consider ways to align private health insurance benefits with Medicaid to better address the needs of the underinsured.
- Encourage or incentivize private payers to simplify and streamline administrative functions and requirements such as credentialing, billing, coding, reporting, etc.

Proposed Amendments and Updates to Mental Health Parity Rule

On August 3, 2023, the federal government released proposed amendments to the Mental Health Parity and Addiction Equity Act (MHPAEA) that, if adopted, could strengthen implementation of the law by employer-sponsored self-funded health plans and insurers in the group and individual markets.[47]

The proposed amendments establish a framework, based on data collection and analysis, for demonstrating that certain treatment limits on behavioral health coverage comply with the parity law. These regulations could provide a structure to help Utah align and enforce parity across different insurance plans and markets.

IV. Improve patient, family, and consumer navigation.

While some discussion group participants perceive that stigma is lessening, the need to improve public awareness of behavioral health is ongoing. This includes increasing behavioral health literacy and providing education that is consumer informed and outcomes focused.

A key component of this education is behavioral health navigation tools that help patients and consumers understand how to access high-quality behavioral health services and help providers manage and coordinate care.

The Master Plan supports strategies that promote effective behavioral health navigation tools that help reduce time between symptom development, identification of need, and engagement in appropriate care in the least restrictive setting (avoiding hospital or institutional-level care when possible). While existing tools could be better promoted and coordinated,[48] it is important to note that the development of future tools should occur after the implementation of major reforms recommended by the Master Plan to account for possible structural changes to Utah's behavioral health systems.

➡ NOW

Key Questions

- How best to help employers understand behavioral health coverage and purchase the best plan and services for their employees?

Focus Areas

- Continue to promote existing navigation services such as the Behavioral Health Navigation Line (833-442-2211), healthyminds.utah.gov, sumh.utah.gov, etc.

- Continue to support, coordinate, and expand local community coalitions and central landing pages that provide resources related to prevention services and other evidence-based programming.[49]

- Partner with patients, families, and consumers to better coordinate, align, and enhance existing navigation services and tools across sectors and geographies.

- Provide more education and awareness of the comprehensive continuum of behavioral health services and supports with a priority focus on (1) prevention and early intervention (to address mild-to-moderate behavioral health needs); and (2) crisis and diversion services as receiving centers and mobile crisis outreach teams (MCOTs) are expanded across the state.

- Partner with patients, families, and consumers to develop effective culturally responsive and linguistically appropriate outreach and education materials as well as materials that meet the needs of individuals with low literacy, low health literacy, and limited-English proficiency.

- Support OPLR's recommendation to empower consumers and regulators to identify and intervene in unprofessional, unlawful, and unsafe conduct by (1) requiring all licensees to immediately report criminal convictions to DOPL (not just declare them at the time of initial licensure/renewal); (2) requiring all clinicians to be enrolled in the FBI "Rap Back" service for ongoing criminal activity checks; (3) authorizing state licensing agencies to query the National Practitioner Data Bank; and (4) requiring clinicians to provide clients with licensing and safety-related disclosures.

➡ NEXT

Focus Areas

- Encourage employees with HDHPs to contribute more to HSA/flexible spending accounts and provide more education on (1) preventive services available at no cost (e.g., depression screening, some anxiety screening, and some services and items related to diagnosed depression);[50] (2) behavioral health access points; and (3) costs related to behavioral health services.

- Implement, evaluate, and possibly expand the statewide bed registry to show bed availability at inpatient, residential, partial hospitalization, med-detox, social detox, receiving/access centers, crisis respite homes,[51] intensive outpatient, and other high-acuity levels of care.

- Create patient, family, and consumer-informed, consolidated, and outcomes-based navigation services that help patients and consumers across the population lifespan (infant to geriatric), and in different areas in the state, access a full continuum of behavioral health services and supports (i.e., the right services at the right time and the right place).

➡ FUTURE

Focus Areas

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

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

Improving crisis services is a current focus for the state, but more can be done to expand these initiatives to ensure all Utahns have access to effective crisis and stabilization services (including referrals to high-quality, community-based care).

Crisis and stabilization services (like Utah's community-based behavioral health receiving centers, Intermountain Health's access centers, and MCOTs) prevent behavioral health issues from escalating and help patients more fully engage in treatment and move to self-sustaining recovery. These services can also help people enter treatment earlier on, and at a lower cost, reducing overall costs in the health care system.

Utah's Behavioral Health Crisis Response Commission is in the process of developing a comprehensive coordinated crisis system designed for anyone, anytime, and anywhere. Key goals include better care, hospital diversion, and law enforcement/jail diversion. The Master Plan supports strategies that align with the Commission's plans as well as additional strategies to expand, enhance, and sustain these services.

➡ NOW

Focus Areas

- Ensure crisis/diversion services across the state are fully integrated with schools, law enforcement, jails, courts, and re-entry programs, and are sufficient to meet the needs of corrections and the criminal legal systems as they develop effective, coordinated diversion strategies.

- Ensure law enforcement, corrections, and the criminal legal systems continue to be trained in best practices to address behavioral health issues and coordinate with behavioral health professionals, peer support specialists, certified case managers, and patient/consumer advocates to improve community responses to behavioral health crises.

- Ensure current crisis services are appropriately funded. Local authorities have limited resources to provide crisis outreach, 24-hour crisis support, and subacute care with their current funding. Additional funding is needed for Utah's crisis response infrastructure to ensure individuals in crisis receive appropriate and quality care.

- Expand access to crisis call centers (with linkages to care), MCOTs, receiving centers with 23-hour observation, and subacute levels of care statewide. Address challenges with expanding rural-area crisis/diversion services.

- Expand private health insurance reimbursement of crisis services (receiving centers, MCOTs, etc.).

- Promote bundled payments for crisis services that reflect regional needs.

➡ NEXT

Focus Areas

- Determine ways to improve coordination between publicly and privately operated crisis/diversion services to maximize availability and access, and improve navigation by patients, consumers, providers, law enforcement, and other sectors and stakeholders across the state.

- Broaden the behavioral health crisis system to integrate SUD intake and treatment more fully.

- Ensure crisis services are integrated into a full continuum of behavioral health services and supports across public and private systems and sectors, ensuring equitable access to a comprehensive system for all Utahns.

- Expand private health insurance reimbursement of evidence-based individual and family respite services and supports and other levels of care (psychosocial rehab, psychoeducation, etc.).

VI **Improve the availability of services and supports for individuals with serious mental illness (SMI) and complex behavioral health needs and their families.**

More services are needed for Utahns with SMI, psychosis, anosognosia, and other complex behavioral health needs. While Utah has some providers qualified and willing to treat these populations, access to services is not consistent across different communities, different populations, and different complex behavioral health conditions.

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

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

➡ NOW

Key Questions

- How to expand Utah's behavioral health workforce qualified to treat SMI, psychosis, anosognosia, and other complex behavioral health needs?

- How to create and promote sustainable reimbursement structures in public and private markets that reflect risk, costs, regional differences, and care complexity?

- What type of payment models or levels of reimbursement are necessary to develop, expand, and sustain community-based subacute services and programs for individuals with complex needs?

- Should public and private markets establish differentiated rates based on risk and outcomes that are appropriate for the population served?

- How to create and determine levels of care? (e.g., clearly articulated "stepped care" approaches that use the American Society of Addiction Medicine's (ASAM) criteria)

- What type of oversight models are effective in managing providers' concerns with private health insurance plans related to subacute, acute, inpatient, and residential behavioral health care coverage and reimbursement?

- How to address the mental health "institutions for mental disease" IMD gap? (e.g., modify the Medicaid waiver)

- What are the current and future needs for civil and forensic beds at the Utah State Hospital?

Focus Areas

- Expand ACT teams across the state and develop a long-term, statewide ACT team plan that includes supporting persons who are unhoused and individuals involved in the criminal legal system.

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

- Identify specific needs and gaps in Utah's community mental health systems, recovery resources, and other supportive services specific to Utah's SMI population (across communities and geographies). Evaluate a range of funding, services, and delivery options, along with best practices and models from other states, to help determine what evidence-based programs, tools, and services could be expanded, supported, coordinated, or developed to fill the gaps.

- Implement autism spectrum disorder (ASD) services for all populations enrolled in Medicaid as part of the Medicaid state plan (per S.B. 204, 2023).

- Consider applying for a Medicaid Katie Beckett Waiver to support children with long-term disabilities or complex medical and behavioral health needs living at home.

- Expand the HMHI HOME Program.

Key Questions

- How to coordinate with the Department of Workforce Services (DWS) and Utah Homelessness Council to ensure integrated, appropriate, and affordable housing options exist statewide to assist persons with behavioral health needs who are unhoused or near-unhoused? [See "Housing: Utah's #1 Issue" text box for more information.]

- How to improve funding and coordination with the Division of Services for People with Disabilities (DSPD) to address the affordability of and gaps in services for persons with ID/DD, including subacute, acute, intermediate, and transitional programs for both youth and adults with co-occurring behavioral health needs? Work with Utah's Institute for Disability Research, Policy & Practice at Utah State University to assess gaps, evaluate why gaps exist, identify best practices, and develop solutions. [See "Mental Health and ID/DD Landscape Analysis" text box for more information.]

- How to best coordinate and enhance services for youth involved in the juvenile criminal legal system?

- Should the state establish a Utah State Hospital operated long-term care facility?

- Consider the development of regionally appropriate medical home models for different populations (e.g., create behavioral health homes for SUDs or support the development or expansion of medical home models that provide care to Utahns with complex behavioral health needs from diverse cultures and communities).

- How to create sustainable funding for addiction recovery services, including improved socialization and standardization of these services?

Focus Areas

- Expand intensive outpatient options by adjusting Medicaid and private health insurance reimbursement models to support sustainability.

- Create sustainable funding/reimbursement models that promote the development and expansion of community-based subacute programs and services that match the right level of care to right level of need and are coordinated with a comprehensive behavioral health continuum of care (consider community-based models, crisis respite homes, individual, family, and crisis respite services, intermediate acuity care models, etc.).

- Promote bundled payments or global fees for episodes of care to improve reimbursement for community-based individual and family respite services and supports, club houses, recovery supports, supported employment/education, and other specialized services such as Coordinated Specialty Care (CSC) for psychosis prevention and early intervention.

- Evaluate ways to make programs that support individuals with co-occurring and complex needs affordable (evaluating changes to state and federal policy, evaluating ways to help individuals pay for treatment through the expansion of subsidies or other assistance programs, etc.).

- Develop or expand reintegration models of care and training for people released from prison.

- Expand the availability of long-term care beds at the Utah State Hospital and other inpatient/residential facilities as needed.

- Create sustainable funding/reimbursement models for acute care services and residential care.

➡ FUTURE

Focus Area

- Ensure equitable access to resources that support the four major dimensions of recovery: (1) health; (2) home; (3) purpose; and (4) community.[52] Examples include but are not limited to individual and family respite services and supports, peer support specialists, CHWs, housing, home and community-based services, supported employment/education, transportation, childcare, access to healthy food, and other social supports.

Housing: Utah's #1 Issue

The most frequently mentioned gaps in Utah's behavioral health systems were affordable housing and housing support services. Nearly all discussion groups noted that there are insufficient housing vouchers, available and affordable housing inventory, and other assistance to address the state's growing housing needs. And while Utah's local authorities, community-based behavioral health providers, and other service organizations provide critical housing support services, they operate with limited resources in an increasingly expensive housing market with little housing stock. Additionally, Utah lacks the availability of permanent supportive housing to address the needs of its most vulnerable residents who are unhoused and have additional needs related to behavioral health.

The lack of affordable housing, permanent supportive housing, and housing support services is disrupting care across the behavioral health continuum—impacting patients and providers. For example, the issue:

- Creates stress and instability that negatively impacts a person's behavioral health and well-being.

- Limits the ability for the system to support care transitions along the continuum such as discharging patients from hospital stays or other high levels of care.

- Increases the number of individuals are unhoused and lengths of stay in shelters, community group homes, recovery centers, and other temporary or transitional programs. This exacerbates challenges related to "step-down" care and the ability to discharge patients from acute/inpatient settings.

- Prevents people in the criminal legal system from effectively participating in court-ordered treatment.

- Exacerbates the state's existing behavioral health workforce shortages. Behavioral health systems across urban and rural areas noted that they are unable to attract talent to their areas due to the lack of homes that are affordable (Figure 9).

In February 2023, the Utah Homelessness Council released Utah's Plan to Address Homelessness.[53] The plan includes five goals:

1. Increase accessible and affordable permanent housing opportunities for people experiencing homelessness across the state.

2. Increase access to and availability of supportive services and case management for people experiencing and at risk of homelessness.

Figure 9: Annual Percent Change in Utah Housing Prices, 1976–2021
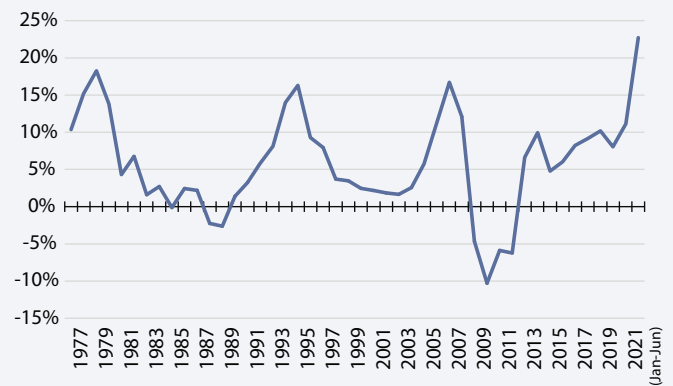
Source: Federal Housing Finance Agency Housing Price Index

3. Expand homeless prevention efforts by increasing coordination, resources, and affordable housing opportunities.

4. Target housing resources and supportive services to people experiencing unsheltered homelessness.

5. Promote alignment and coordination across multiple systems of care to support people experiencing and at risk of homelessness.

The Master Plan supports these goals and working with the Utah Office of Homeless Services during the plan's implementation process[54] to ensure future versions of the Master Plan align with Utah's Plan to Address Homelessness.

The Master Plan also supports the following focus areas:

- Expand and ensure case management is available to diverse populations to address a range of social determinants of health (SDOH) including housing and services for persons who are unhoused. Maintain sufficient case management workforce with sustainable reimbursement by Medicaid, private insurance, and other funding for uninsured and underinsured populations—while also reducing unnecessary administrative burdens (see strategic priority #7).

- Develop enhanced, regionally based referral networks to support case managers and other providers with patient/consumer navigation and connecting to existing housing resources and supports.

- Expand and sustain integrated permanent supportive housing, scattered-site housing, assisted living, and other community and residential support programs across the state by providing long-term rental subsidies as well as sufficient funding to develop, support, and

Housing: Utah's #1 Issue *(Continued from previous page)*

maintain the housing over time. Models should include community-based, group settings where staff (ACT teams, peer support specialists, etc.) are available to assist residents with activities of daily living and retain housing throughout the recovery process (including relapse). Models should also align with best practices, including SAMHSA's Permanent Supportive Housing Evidence-Based Practices Kit[55] and the Corporation for Supportive Housing's Standards for Quality Supportive Housing Guide.[56]

- Evaluate the possibility of expanding Utah's Housing Related Services and Supports (HRSS) program to additional Medicaid populations and/or cover additional services and supports such as case management.[57] The HRSS program allows the state to provide housing-related supports and services to the Targeted Adult Medicaid (TAM) population through its 1115 waiver.

- Evaluate the possibility of expanding Medicaid's presumptive eligibility to people receiving medical services in federally qualified health centers and other community health centers.

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

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

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

Key recommendations and next steps in the report include:

1. Directly involve individuals with mental health and/or ID/DD lived experience (including practitioners and family members/caregivers from diverse backgrounds) in the decision-making process regarding allocation and distribution of funds at state and local levels.

2. Provide support (funding, policies, etc.) for improved collaboration between mental health and disability service sectors to facilitate coordinated care.

3. Provide professional development opportunities that support the provision of mental health services for individuals with ID/DD through increasing mental health provider knowledge and confidence.

4. Institutes of higher education and advanced training should review and update their curricula to reflect specific needs of individuals with ID/DD in the mental health setting.

5. Value the critical role of direct support professionals in disability service systems through continuing to support competitive wages and providing effective training and ongoing professional guidance. This will enable direct support professionals to identify and address mental health needs among individuals with ID/DD within their scope of work.

The results of the landscape analysis were finalized in September 2023.

VII Expand, support, and diversify Utah's behavioral health workforce.

Utah's ongoing—and growing—behavioral health workforce shortages are disrupting care across the state and continuum of behavioral health services and supports. The Master Plan supports strategies to (1) attract, retain, and develop a diverse behavioral health workforce (culturally responsive and representative of Utah's diverse cultures and communities); (2) grow and develop a sustainable behavioral workforce across provider types from prescribers (including primary care providers trained in behavioral health screenings, early intervention, and treatment of mild-to-moderate behavioral health issues), to psychologists, to licensed, certified, and professionals/para-professionals; and (3) create supports and incentives for clinicians to work to the top of their license. Many of these strategies are being developed and promoted by the Utah Substance Use Advisory and Mental Health Advisory Council (USAAV+),[58] Utah's Health Workforce Advisory Council,[59] and Utah's Area Health Education Centers (AHEC).[60]

Figure 10: Building out Workforce Extenders to Support Utah's Behavioral Health Workforce
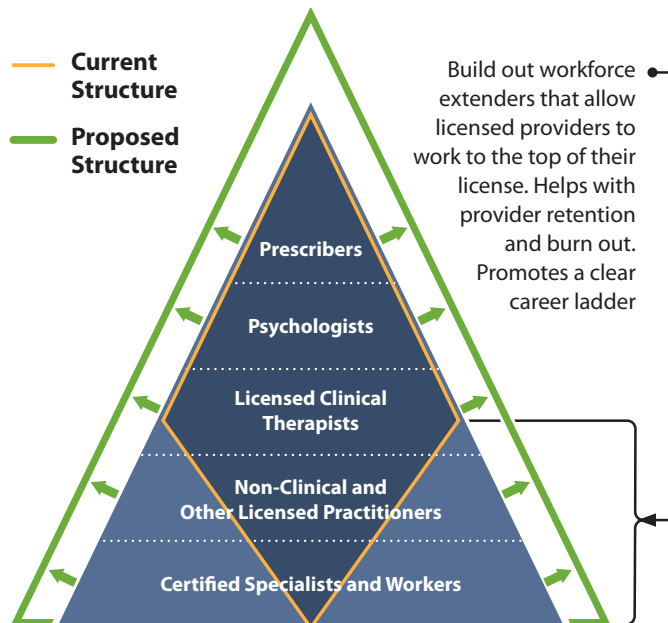
Examples of prescribers include psychiatrists, APRNs, and primary care providers. Examples of licensed clinical therapists include MFTs, LCSWs, CHMCs, MACs, and ASUDCs. Examples of non-clinical and other licensed practitioners include social workers, behavior analysts, SUDCs, and Behavioral Health Technicians (in development). Examples of state certification specialists and workers include peer support specialists, family peer support specialists, certified case managers, community health workers trained in mental health/SUDs, and certified crisis workers.

Note: Graphic is for illustrative purposes only and is not a comprehensive depiction of Utah's current or planned workforce. Data from OPLR's review of mental and behavioral health licenses in Utah show Utah's behavioral health workforce is currently missing the base levels, resulting in a diamond shape. Building out the sections that require less training (i.e., certified or credentialed non-licensed professionals) could help address Utah's shortages. Source: Kem C. Gardner Policy Institute. Based on OPLR's review of mental and behavioral health licenses in Utah.

The Master Plan also includes a specific focus on increasing the use of certified or credentialed non-licensed professionals (peer support specialists, family peer support specialists, certified case managers, certified crisis workers, CHWs, etc.) to extend Utah's current workforce and improve access to community recovery supports across the state (Figure 10). Effective use of certified or credentialed non-licensed professionals as part of an integrated care team can:

- Support appropriate task shifting[61] to help both licensed providers and certified non-licensed professionals work more effectively to the top of their license (which helps with retention and burn out);

- Promote a clear career ladder within the behavioral health field for individuals who wish to move into different positions;

- Create a workforce that is more inclusive and mirrors individuals served (which helps reduce inequities, disparities, and stigma); and

- Assist with care transitions and patient navigation.

Certified or credentialed non-licensed professionals should have appropriate funding, support, training, supervision, oversight, and experience to be successful, avoid burnout, and ensure the best use of their skills. Training and supervision should be based on best practices as outlined by SAMHSA[62] and other evidence-based resources.

It will also be important to monitor and respond to potential bottlenecks across the various strata of the workforce (Figure 10).[63] There is no agreement on the optimal mix of non-licensed professionals to licensed professionals for specific interventions. However, some large-scale mental health reform efforts found value in having a higher proportion of licensed professionals.[64] If the target population for the intervention has more severe or complex needs, then the proportion of licensed professionals could be even higher. Having an insufficient proportion of licensed professionals could create problems with referrals and exacerbate issues with access,[65] which is why Utah remains focused on expanding, supporting, and diversifying all levels of Utah's behavioral health workforce.

NOW

Key Questions

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

Focus Areas

- Maintain advancements made to telehealth during the COVID-19 Public Health Emergency (PHE), including ensuring meaningful and equitable reimbursement.

- Determine effective ways to help sustain culturally responsive and language accessible behavioral health providers to meet the needs of Utah's changing demographics. Funding should be equitable, flexible (e.g., SUMH's multi-cultural affairs grant), and sustained over time.

- Support OPLR's recommendations to (1) expand existing DHHS certification programs; (2) create a voluntary, entry-level state certification for a "behavioral health technician" (a one-year behavioral health educational certificate meant to bridge the gap between state certifications and bachelor's- and master's-level licenses); and (3) create a bachelor's-level generalist behavioral health license.

- Support OPLR's recommendation to optimize licensure regulation of clinical therapists to allow greater flexibility in supervision and continuing education while maintaining and promoting safe practice.

- Support OPLR's recommendation to create a Master Addiction Counselor (MAC) license, which provides a path for existing clinicians to work at their highest level of competence and for prospective clinicians to advance in the substance use disorder counseling (SUDC) subspecialty.

- Establish Medicaid reimbursement for CHWs (develop state plan language that is broad enough to encompass behavioral health issues and referral supports).

- Partner with community-based, peer-led organizations to develop effective ways to support, train, sustain, and expand Utah's certified or credentialed non-licensed professional behavioral health workforce.

- Provide coordinated training, technical assistance, and education to physical and behavioral health providers, schools, and other sectors and settings on how best to deploy non-licensed professionals as care team members to improve adoption of effective strategies, support coordination, and avoid inappropriate use.

- Improve the certification process and standardize training of non-licensed care team members to help reduce quality differences.

- Continue to promote and support the training of behavioral health providers working with and providing services to Utahns from diverse cultures and communities. [See organizational, structural, and service-level reforms outlined in the "Health Disparities in Utah's Public Mental Health and Substance Use Treatment Systems Needs Assessment" for specific recommendations].

- Support Utah's behavioral health workforce adopt, expand, or develop models that address stigma (leveraging peer supports within the workforce, encourage help-seeking behaviors, etc.)

- Support OPLR's recommendation to enable behavioral health professionals to confidentially seek recovery assistance while maintaining their license by expanding the Utah Professionals Health Program (UPHP) to (1) include behavioral health professionals; and (2) cover mental health conditions for all covered professionals.

NEXT

Key Questions

- What levels of reimbursement, grants, and additional resources are needed to expand peer supports, case managers, CHWs, and other non-licensed care team members? How to equitably distribute these resources to community-based and nonprofit organizations?

Focus Areas

- Support OPLR's recommendation to ensure portability of licensure across state lines so behavioral health workers moving to Utah can resume practice without interruption.

- Promote use of bundled payments that reflect regional needs to improve reimbursement for peer supports, CHWs, case management, etc.

- Expand public and private health insurance reimbursement of research-supported recovery-based models that rely on non-licensed professionals such as peer supports, case managers, etc.

- Determine effective ways to help sustain community-based organizations that support peer support specialists and other non-licensed providers. Funding should be equitable, flexible, and sustained over time.

Key Questions

- How to create incentives for enhancing the workforce pipeline across all provider types, across the state, and across Utah's diverse cultures and communities (e.g., loan repayment programs)?

- How to address structural barriers that may prevent persons from participating in Utah's behavioral health workforce while maintaining safety? (licensure exams that are not culturally responsive or adapted to the experiences of Utah's diverse cultures and communities, background checks, etc.)

- How best to partner with people in recovery and create pathways for them to work and advance within certified non-licensed professional roles and broader behavioral health fields if desired?

- What methods are most successful in educating high school students on behavioral health careers to create a more robust future workforce? (e.g., connect with AHEC)

Focus Areas

- Support OPLR's recommendation to create alternative state licensure pathways for clinical therapists, allowing additional qualified applicants into the workforce, especially from non-traditional backgrounds.

- Evaluate pathways for upward mobility by developing career ladders through bridge and/or tuition support programs to allow non-licensed professionals to train and obtain certification or licensure to advance within their field or into the clinical system if desired.

- Encourage health plans to demonstrate provider networks that are geographically accessible, offer timely care during convenient hours, and are language accessible, culturally responsive, and qualified to treat Utahns from diverse cultures and communities (could include contracting with a workforce that is grounded in peer recovery, peer support, case management, and community based as well as leveraging telehealth and effective digital tools).

- Promote public-private partnership service delivery models that offer incentives for providers and public payers to reach underserved areas and populations in Utah.

- Teach more SUD content and culturally responsive approaches in higher education, training, and certification programs.

Overview of the Environmental Scan Process

METHODOLOGY

The Gardner Institute and LP/HMA conducted an environmental scan to understand current behavioral health initiatives; gaps in services; challenges, barriers, inequities, and needs related to providing and accessing behavioral health services; and the changing and future needs of stakeholders connected to Utah's behavioral health systems.

Four components comprise the environmental scan: (1) building on previous assessments; (2) reviewing updated reports, information, and data related to Utah's behavioral health systems; (3) capturing recent changes; and (4) collecting qualitative information through discussion groups, interviews, and other feedback mechanisms.

Previous Assessments

The environmental scan builds on and expands previous research and system assessments conducted by the Gardner Institute including an overview of Utah's Mental Health Systems (2019),[66] Utah's Early Childhood Mental Health System (2020),[67] and Medication-Assisted Treatment for Opioid Use Disorder in Utah (2020).[68] More information about Utah's behavioral health systems is available in these reports.

The environmental scan also builds on two recommendation-based reports:

1. In February 2020, UHA released A Roadmap for Improving Utah's Behavioral Health System.[69] UHA developed the Roadmap in collaboration with its behavioral health committee and mental health workgroup. The Roadmap includes a set of tiered recommendations that primarily focus on mental health and represent initial steps to system improvement.

   A 2021 End-of-Year Update[70] to the Roadmap, released in December 2021, details recent initiatives and remaining gaps related to the recommendations.

2. In March 2022, The Children's Center Utah released A Pathway for Improving Early Childhood Mental Health in Utah.[71] The Children's Center Utah assembled the Utah Early Childhood Mental Health Working Group in 2021 to develop strategies and tactics to strengthen and improve early childhood mental health in Utah in response to the "Early Childhood Mental Health in Utah" report. [See "Meeting the Mental Health Needs of our Infants, Children, and Youth" text box for more information.]

Recognizing the importance of addressing both mental health and SUDs across the lifespan, UHA and DHHS decided to engage in the Master Plan process to conduct a broader assessment and develop set of recommendations that consider the many sectors connected to or impacted by behavioral health. These include, but are not limited to public and private mental health and SUD systems and providers, public and private physical health systems and providers, Medicaid and private health insurance plans, housing and services for persons who are unhoused, child welfare, services for persons with disabilities, K-12 schools, higher education, and the court and criminal legal systems (including corrections and law enforcement).

Updated Reports, Information, and Data

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

While this review was comprehensive, it does not include all reports, information, data, and initiatives given the tremendous amount of public and private sector work currently occurring within Utah's broad behavioral health systems.

Recent Changes to Utah's Behavioral Health Systems

It is also important to acknowledge recent changes that have, are, or will influence Utah's behavioral health systems. These include, but are not limited to:

- DHHS assuming responsibility for health care in Utah's prison system beginning July 1, 2023.

- Opioid Settlement Fund payments (started October 31, 2022).

- Merger of the Utah Department of Health and Department of Human Services (July 1, 2022).

- Creation of the Utah Homelessness Council and state Homeless Coordinator (2021).

- Creation of the Education and Mental Health Coordinating Council (2021).

- Expansion of Utah's crisis system, including receiving centers and MCOTs (all counties in the state currently have access to active MCOTs) (2020-2023).

- Expansion of the Behavioral Health Crisis Response Commission and establishment of 988 as a nationwide 3-digit number for mental health crisis and suicide prevention services (2021-2022).

- Full Medicaid expansion (January 2020), which extended Medicaid coverage to Utah adults with annual income up to 138% FPL. The federal government covers 90% of the costs for these services, with the state covering the remaining 10%.

- Utah Medicaid Integrated Care (UMIC) program that manages physical and behavioral benefits for Utah Medicaid's adult expansion population through integrated managed care plans in five counties: Davis, Salt Lake, Utah, Washington, and Weber (January 2020).

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

- S.B. 86: Designed to reduce fentanyl overdose deaths by decriminalizing the use of fentanyl test strips.

- S.B. 133: Provides 12-month postpartum coverage for low-income new mothers. Expanded postpartum coverage can help address issues like postpartum depression and anxiety and provide reimbursement for necessary medication (Figure 11).

- H.B. 66: Provides over $5 million in new funding to add new receiving centers and MCOTs.

- H.B. 166: Allows for the provision of some remote mental health therapy and substance use disorder counseling.

- H.B. 248: Provides an additional $1 million in funding for adult mental health services.

It is also worth noting that the COVID-19 pandemic increased behavioral health needs and impacted the systems in place to serve Utahns. These impacts are considered in this report.

Discussion Groups, Interviews, and Feedback

The Gardner Institute and LP/HMA conducted 30 formal discussion groups and in-depth interviews from June 2022 to January 2023, engaged in many informal interviews with additional groups, and collected further feedback by soliciting comments on a draft version of the Master Plan (see "Key Findings from the Assessment" on p. 5 for more information).

The goal of the discussion groups and interviews was to gather information for a comprehensive review of Utah's behavioral health systems as well as to collect ideas from a broad group of stakeholders on system improvements.

An overview of the detailed findings from the discussion groups and interviews are presented in the subsequent sections. The information is organized along the same segments presented in the continuum of behavioral health services and supports (Figure 1). Each section includes information from the discussion groups and interviews related to:

- Gaps, challenges, and needs.

- Bright spots (highlights or successes mentioned during the discussion groups). While not every bright spot in Utah's behavioral health is captured here, it is important to acknowledge what is working well to avoid unintentional consequences when developing reforms.

- Suggested ideas for next steps. Many of these ideas are included in the Master Plan, but not all suggested next steps align with current focus areas identified in the Master Plan.

ABOUT QUALITATIVE RESEARCH

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

Figure 11: Share of New Mothers Reporting Postpartum Depression Symptoms, 2012-2021
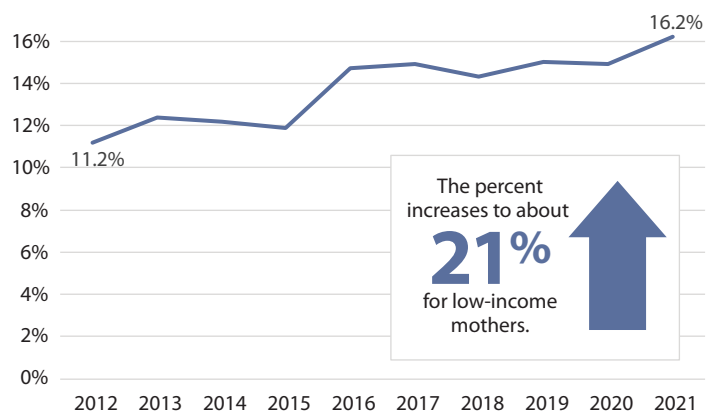
Note: The data represent self-reported postpartum depression symptoms and not clinical diagnoses of postpartum depression.
Source: The Utah Department of Health and Human Services Pregnancy Risk Assessment Monitoring System (PRAMS)

Environmental Scan: Detailed Findings

PROMOTION AND PREVENTION

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

> ### 50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24.[72]

Gaps, Challenges, and Needs:

- *Stigma.* While mental health stigma has lessened over the last few years, it still exists, particularly for residents in rural areas, active military and veterans, populations who are unhoused, persons in the criminal legal system, transition-age youth and young adults, BIPOC, LGBTQ+ communities, people with developmental disabilities, and families accessing child and family services (due to fear and distrust of the child welfare system). Stigma is also associated with SUDs, including stigma from medical providers due to lack of training. This can make it difficult to provide SUD care in an integrated setting. [See "People Need Hope" text box for more information on stigma.]

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

- *Insufficient funding.* Promotion, prevention, and community education programs (see section below) need more funding, resources, and support to be sustainable and generate long-term impacts. This includes:
  - Federal and state funding (e.g., more federal block grant funding directed to mental health and SUD prevention).
  - Adequate reimbursement for mental health and SUD prevention services provided in a medical or behavioral health treatment setting (e.g., screenings).
  - Community-directed discretionary funding for behavioral-health focused promotion and prevention services. Many community-based prevention and education programs focus only on physical health and nutrition.

- *Lack of system coordination and "siloed" prevention systems.* There are several coalitions addressing similar risk and prevention factors. While each of these coalitions have a specific purpose, better alignment could help create more efficiencies within the system. Other issues include:
  - Many health systems are developing or utilizing their own promotion, prevention, or early identification programs, tools, and services, which may not be aligned with or connected to the broader system, creating challenges with transition support and patient navigation.
  - Some programs do not have the resources or financial support to expand beyond a specific population or region, adding to existing system silos and the need to duplicate services.
  - There is not a single point of contact or resource directory related to prevention, which makes it difficult to know how or where to access prevention, parenting, educational, and early intervention programs.
  - As a specific example, participants suggested that the court system could be better connected to the state's existing prevention efforts to better address the needs of its population before they commit serious crimes for which they may be incarcerated.

Figure 12: Suicide Rate by State, 2020
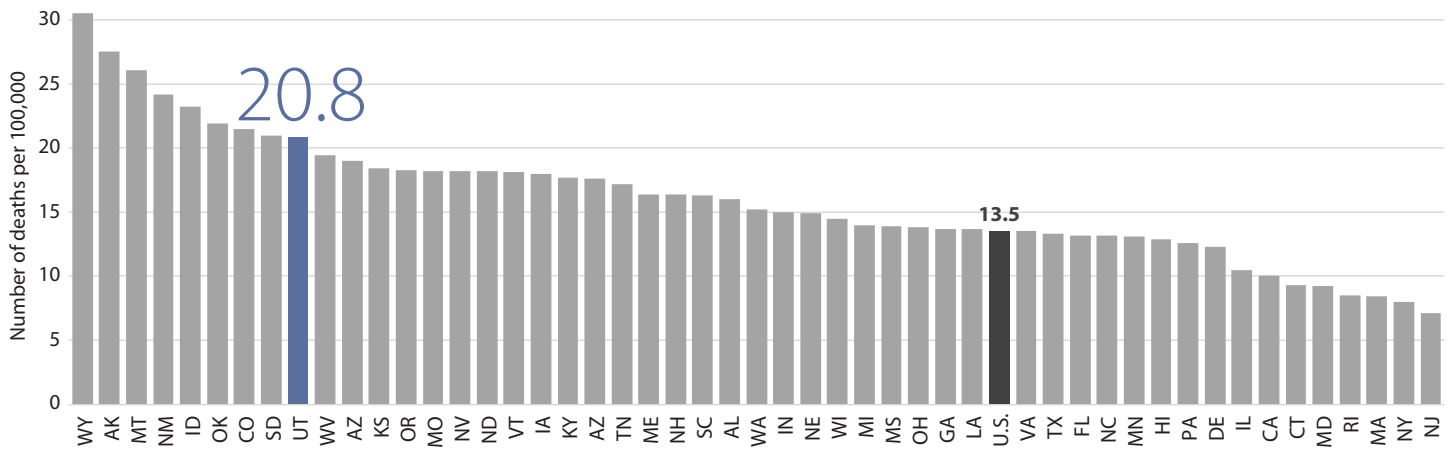
Note: Suicide rates are adjusted for differences in age-distribution and population size.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Bright Spots:

- *Utah has an existing base to build on.* Utah has a mature, evidence-based, well-organized prevention system that can be built on and expanded.

- *Increasing focus on prevention efforts by both the Utah Legislature and state agencies.* Examples include:

  – Prevention being a primary focus for Utah's opioid settlement funds.[73]

  – DHHS supporting Blueprints for Healthy Youth Development Programs,[74] a registry of evidence-based positive youth development programs designed to encourage the health and well-being of children and teens.

  – The Utah Legislature appropriating significant funding to suicide prevention (including the Governor's Suicide Prevention Fund) and suicide prevention training.

- *Live On Suicide Prevention Campaign.* "Live On"[75] is a public-privately funded suicide prevention campaign that receives financial support from the Legislature, Governor's Office, SUMH, Intermountain Health, and other groups. It is supported by the Utah Suicide Prevention Coalition, a partnership of community members, suicide survivors, service providers, researchers, and others dedicated to saving lives and advancing suicide prevention efforts in Utah.[76] The campaign's goal is to advance efforts to educate the public about the warning signs of suicide, how to listen and intervene, and to save lives by linking individuals to appropriate services. [See "Utah's Suicide Rate is High, but Declining" text box for more information.]

Utah's Suicide Rate is High, but Declining

Utah's suicide rate was 20.1 per 100,000 population in 2021.[77] Utah's rate has continued to decline in recent years, from a high of 22.7 deaths per 100,000 total population in 2017. However, suicide rates among Utah males are close to four times higher than the rate among Utah females (31.8 vs. 8.3 per 100,000 population, 2021).[78] Rates are also highest among Utah's American Indian/Alaska Native populations (21.2, 2019-2021 combined data).[79] Utah's suicide rate was 9th highest in the country in 2020 (Figure 12, 2021 data for all states was not yet available).

- *HMHI anti-stigma working groups.* HMHI hosts monthly Utah Mental Health Anti-Stigma community meetings open to any Utah individual or organization working to eliminate the stigma around mental health and SUDs. This stakeholder community has eight working groups focused on specific stigma contexts (health care, workplace, etc.) made up of 125 diverse individuals representing many populations and sectors from across the state (e.g., health care, business, nonprofit, schools, and government leaders). The goals of the Utah Stop Stigma Together Initiative are to create a social movement that changes public perception about stigma related to mental health and SUDs, build a leadership community in Utah that works collaboratively to eliminate stigma, and to address population specific needs.

- *Governor Cox's social media initiative.* In October 2022, Governor Cox announced the creation of the Office of Families, under the Division of Family Health, which will focus on addressing social media's negative impact on teens. The Governor also worked with legislators to pass

S.B. 152 (2023), which requires a social media company to verify the age of a Utah resident seeking to maintain or open a social media account; requires a social media company to obtain the consent of a parent or guardian before a Utah resident under the age of 18 may maintain or open an account; and prohibits a social media company from permitting a Utah resident to open an account if that person does not meet age requirements under state or federal law, among other points.[80] In March 2023, the Surgeon General issued an advisory about the effects of social media use on youth mental health.[81] The advisory cites research that shows that "adolescents who spend more than three hours per day on social media face double the risk of experiencing poor mental health outcomes, such as symptoms of depression and anxiety." The advisory also notes that most teenagers spend an average of 3.5 hours per day on social media.

Suggested Ideas for Next Steps:

- Maintain support for the Utah Student Health and Risk Prevention (SHARP) survey and other data collection efforts that identify mental health and SUD needs (e.g., rates and regional variation).

- Develop a common certification or a minimum set of training criteria for prevention specialists and others providing prevention services across the state (similar to certified education counselors). A concern raised with this idea is that some areas of the state (such as rural and frontier communities) may lack the financial capacity to support certification or pay for certified prevention specialists, indicating that this may require a statewide funding approach.

- Work with Utah's higher education institutions to incorporate more training on evidence-based SUD prevention in their medical and behavioral health graduate education programs and/or consider adding certified crisis worker curriculum into training programs.

- Encourage state leaders (legislators, program directors, etc.) to complete prevention training to enhance their understanding of the science behind prevention activities.

- Fund and support an expanded prevention infrastructure at both the state and local levels (staffing, programming, etc.). This could include training to help people understand concepts and develop key components that are needed for delivering effective prevention programs and services (inclusivity, addressing risk and protective factors, developing safe and supportive policies and environments, providing referrals, and supporting access to care, etc.)

- Improve reimbursement for prevention services. This could include creating or updating codes for prevention services and ensuring health plans cover and reimburse them at sustainable rates (SBIRT, SDOH screening, etc.). Funding and supporting an expanded prevention infrastructure (as discussed above) could help ensure sufficient prevention services are available for access and referral.

- Create a central repository where health, behavioral health, child welfare, juvenile and adult criminal legal systems, courts, Adult Probation and Parole (AP&P), faith-based organizations, and the public could refer individuals and families to resources.

- Fund and support community coalitions while encouraging more collaboration. Community coalitions address targeted, local needs and seek to prevent the escalation of behavioral health issues by establishing connections with key community stakeholders such as courts, law enforcement, and schools. Encouraging more collaboration among these coalitions could result in more targeted communication, education, and behavioral health prevention efforts. The state could consider developing or promoting a model or best practices for how these coalitions can work together and engage with different sectors. One example of a best practice in this area is the work being completed with Utah's Criminal Justice Coordinating Councils, which are formed by a county or counties to coordinate and improve components of the criminal legal system in the county.[82]

- Create forums to share successes and best practices. These forums could help increase awareness of behavioral health needs within a community, what is working well to address them, and ways to help secure and sustain funding.

COMMUNITY EDUCATION & SERVICES

Community education and services include behavioral health services provided in a community setting such as in schools, faith-based organizations, nonprofit organizations, etc. The state supports community education and services through continued funding of the SafeUT app and recent expansions of school-based mental health through the Elementary School Counselor Program (2018) and the Student Health and Counseling Support Program (2019) to address the growing mental health needs among Utah's youth. [See "Mental Health Needs Among Utah's Youth" text box for more information.]

Gaps, Challenges, and Needs:

- *Duplication of effort and lost efficiencies between K-12 mental health services and supports and the broader behavioral health system.* Several discussion groups mentioned the unintended consequences the increase in school-based mental health professionals has on broader behavioral health systems. Specific concerns relate to:

  – Exacerbating workforce shortages. Increasing the number of school-based mental health professionals resulted in hiring therapists, social workers, and other licensed mental health professionals from existing mental health providers and systems. "We ended up robbing Peter to pay Paul."

  – Not utilizing school-based mental health professionals to the top of their license. Participants were concerned that some licensed mental health professionals working in K-12 settings are focused more on school academics, class scheduling, and providing testing for individual education plans (IEPs). Addressing the state's current workforce shortages requires that mental health professionals be able to work to the top of their license.

  – Not utilizing funding for its intended purpose. State and local funding dedicated to this initiative was intended to be collaborative. Instead, discussion groups felt some schools are not using the funding to support mental health, but rather academic school counselors who

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Mental Health Needs Among Utah's Youth

National research shows Utah is among a group of states with the highest prevalence of child and adolescent mental health disorders and the highest prevalence of youth with untreated mental health needs (see Figures 13, 14, and 15).[83]

Figure 13: Select Mental Health Indicators Among Children Ages 6-11 in Utah and the U.S., 2020-2021 combined
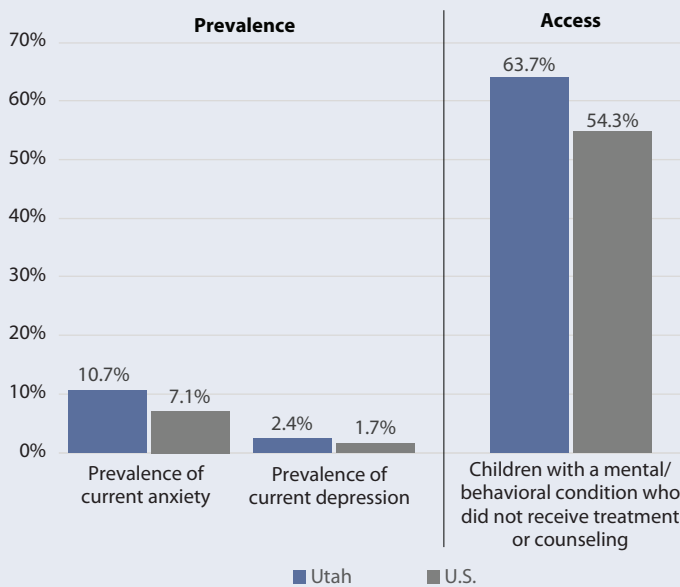
Note: The third column represent children reported by their parents to have been diagnosed by a health care provider with a mental/behavioral condition (depression, anxiety problems, or behavioral or conduct problems). Some estimates have a 95% confidence interval width exceeding 20 percentage points and should be interpreted with caution.
Source: Child and Adolescent Health Measurement Initiative. 2020-2021 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 05/19/23 from www.childhealthdata.org.

Figure 14: Share of Utah Middle and High School Students with Mental Health Needs, 2015-2021
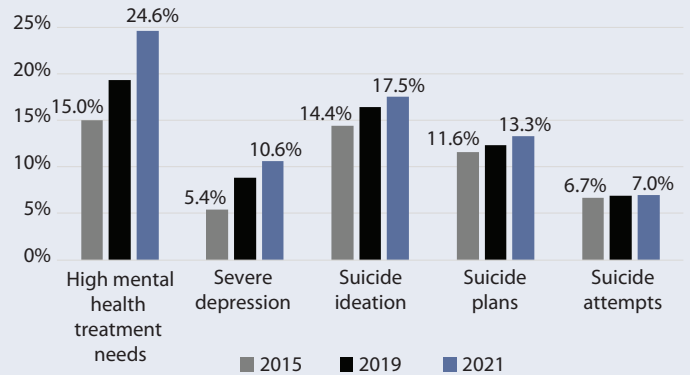
Note: Survey responses are from students in grades 6, 8, 10, and 12.
Source: Utah Student Health and Risk Prevention: Prevention Needs Assessment Survey. Utah Office of Substance Use and Mental Health.

Figure 15: Access to Treatment or Counseling for Utah Children with a Mental/Behavioral Condition Ages 12-17, 2020-2021 combined
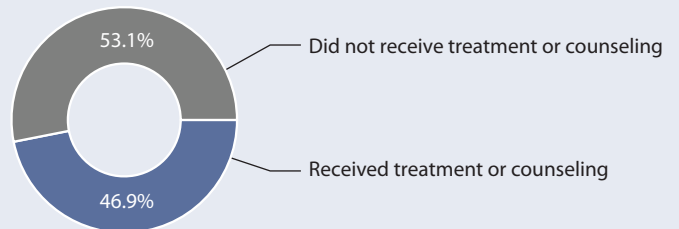
Note: Data represent children reported by their parents to have been diagnosed by a health care provider with a mental/behavioral condition (depression, anxiety problems, or behavioral or conduct problems). Some estimates have a 95% confidence interval width exceeding 20 percentage points and should be interpreted with caution.
Source: Child and Adolescent Health Measurement Initiative. 2020-2021 NSCH data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, HRSA, MCHB. Retrieved 05/19/23 from www.childhealthdata.org.

may not be fully tuned into mental health issues, training, and supports. Some discussion groups also felt the level of funding schools received was not commensurate with the interventions being provided.

– Lack of appropriate training. Participants expressed a need for the state to provide more guidance to school-based mental health professionals and school counselors regarding best practice approaches for providing behavioral health treatment in schools. Better training is also needed on how to bill Medicaid, which can be administratively burdensome.

– Lack of connectivity to community behavioral health providers and the creation of a siloed system. Some school-based mental health professionals may only provide limited interventions and are not connected to a broader continuum of care and specialty providers, including case managers, family peer support specialists, and psychiatric prescribers (who are needed to treat more complex mental health issues).

• *Potential for duplication between higher education institutions' behavioral health services and broader behavioral health systems.* Utah's higher education institutions are experiencing escalating demand for behavioral health services (Figure 17 shows the share of young adults with poor mental health more than doubled over the last 10 years). [See "Mental Health Needs Among Utah's Young Adults" text box for more information.] Utah's public higher education institutions, including its technical colleges, are participating in the JED Campus program,[84] which is "a four-year collaborative process of comprehensive systems, program, and policy development with customized support to build upon existing student mental health, substance misuse, and suicide prevention efforts."[85] As these schools begin implementing their strategic plans, it will be important to connect to and leverage resources within broader behavioral health systems where possible to avoid adding to the system's current workforce shortages and creating more siloed systems.

Mental Health Needs Among Utah's Young Adults

The percentage of young adults with serious thoughts of suicide increased in the past year (9.5% to 14.7%) as has the percentage of young adults with SMI (5.4% to 11.7% from 2008–2010 to 2017-2019, Figure 16). Utah's rates are estimated to be higher than the national average, with the prevalence of young adults with SMI being statistically significant.[86]

Figure 16: Share of Utah's Adults Ages 18-25 with Select Mental Health Needs, 2008-2010 vs. 2017-2019 combined
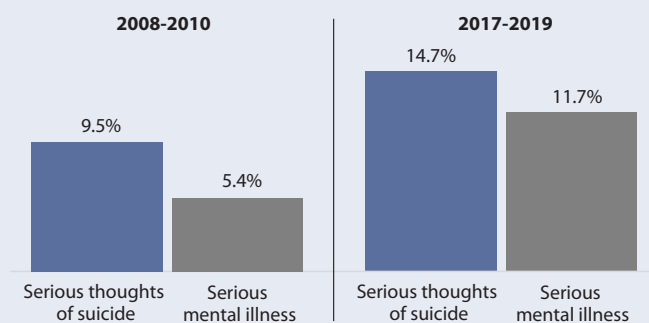
Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016–2019.

Figure 17: Share of Utah Adults Ages 18-25 With Poor Mental Health, 2011-2021
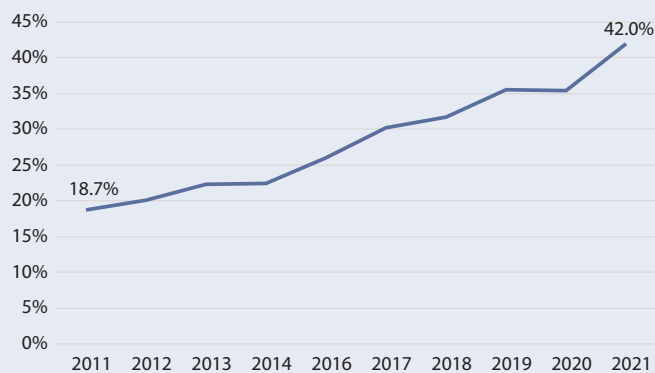
Note: Share of adults reporting seven or more days with not good mental health. "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services.

Figure 18: Share of Children Under Age 3 with Mothers Experiencing Poor Mental Health in Utah and U.S., 2018-2020 combined
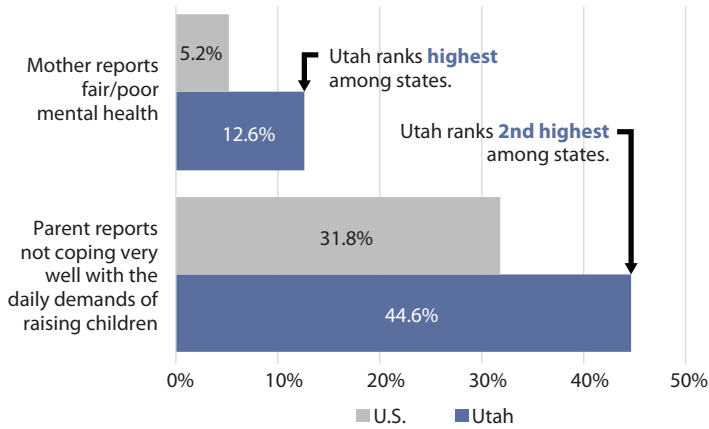
Source: US Department of Health and Human Services (HHS), HRSA, MCHB. (2019-2021). 2018-2020 National Survey of Children's Health NSCH Public-Use Data. From Prenatal-to-3 State Policy Roadmap.

- *Improved connectivity with childcare providers and the infant and early childhood mental health system.* While opportunities for Utah's daycare, preschool, and other childcare providers to receive best practice training on infant and early childhood mental health are improving, more coordinated work in this area is needed given the share of children under age three with mothers who experience poor mental health (Figure 18). Like the K-12 system, many childcare providers are not connected to the state's infant and early childhood mental health system (which, in many cases, is also not connected to a broader behavioral health continuum of care). Creating this connectivity is more difficult in the childcare space than the K-12 space, given there is not a coordinated daycare, preschool, or childcare system.

- *Lack of behavioral health outreach services and supports.* Behavioral health outreach services, like Stabilization and Mobile Response Teams, are not well-funded, which are important services for children with serious emotional disturbance (SED), as well as adults with SMI, individuals with SUDs, and individuals who are chronically unhoused.

- *Improved connectivity between tobacco cessation and mental health and SUD treatment.* The nicotine dependency rate for individuals with behavioral health conditions is 2-3 times higher than the general population[87] and the Utah Tobacco Quit Line reported 65% of total callers noted having a behavioral or mental health condition in

2022. This coupled with the high utilization rate of Utah's cessation services among persons with behavioral health conditions is both an indicator of higher prevalence, and interest in quitting tobacco. Integrating tobacco cessation into the treatment of alcohol and other SUDs helps clients and improves treatment[88] (a meta-analysis of 18 studies found that treating the tobacco use of clients improved their alcohol and other SUD outcomes by an average of 25%[89]). Research also shows people with alcohol use disorders are as successful at quitting tobacco as people without alcohol use disorders.[90] [See "Barriers to Tobacco Cessation Services and the Connection to Behavioral Health" text box for more information.]

Bright Spots:

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

- *Tobacco cessation resources are available to be better integrated into mental health and SUD treatment.* Providing tobacco cessation assistance to individuals with behavioral health conditions is linked with improved mental health—including reduced depression, anxiety, stress, enhanced mood and quality of life.[91] The Utah Tobacco Prevention and Control Program (TPCP) offers a variety of free quit services, including telephone counseling, web-based counseling, email, and text messages, and nicotine replacement therapy (NRT) medications. Collectively, these services are offered through the Utah Tobacco Quit Line or WayToQuit.org.

Barriers to Tobacco Cessation Services and the Connection to Behavioral Health

Barriers to Tobacco Cessation

The Utah Tobacco Prevention and Control Program (TPCP) collaborated with RTI International in 2022 to conduct a series of focus groups with adults who identified as currently using tobacco products to better understand barriers to tobacco cessation services and utilization of the Utah Tobacco Quit Line. TPCP also surveyed peer support specialists throughout the state to assess their perception of Utah Tobacco Quit Line services.

Participants stated shared challenges to quitting tobacco included mental health issues such as stress, depression, and anxiety. Many participants shared that they often used tobacco as a coping mechanism and that they struggled in their quit attempts when dealing with stressful situations or mental health issues.

Some participants shared that they needed alternative or healthier coping mechanisms to replace tobacco. A few participants mentioned that their most successful quit attempts were during times of behavioral treatment or involvement with the criminal legal system. Several participants who currently use tobacco and are also receiving behavioral health treatment noted a desire to quit tobacco. Participants who never sought cessation services were unaware of some or all the Quit Line's services.

Dispelling Myths

The commercial tobacco industry "invested significant resources to connect tobacco with mental health, including giving away cigarettes to psychiatric facilities, supporting research that positions cigarettes as a way to self-medicate, and using stress relief themes in marketing."[92] These actions perpetuated myths and normalized smoking behavior in behavioral health treatment settings, both among staff and clients.

Common myths include: (1) tobacco use can be necessary self-medication for people with mental health issues; (2) people with mental health issues are not interested in quitting smoking or cannot quit smoking; (3) quitting smoking interferes with recovery from mental health conditions; and (4) smoking is the lowest priority for patients with acute psychiatric symptoms.[93]

Improving Training for Peer Supports

Surveyed peer support specialists expressed interest in receiving training to implement tobacco cessation work. When asked how much they consider it a priority for their clients, they rated quitting smoking 3.83 out of 5, vaping 3.7 out of 5, and other substances 4.61 out of 5. Fifty-four percent of the peer support specialists that have not recommended Quit Line services to their clients indicated lack of awareness of Utah Tobacco Quit Line services as the reason.

Suggested Ideas for Next Steps:

- Improve collaboration between K-12 mental health services and supports and broader behavioral health systems by:

  – Providing more education or training on the roles and responsibilities of school counselors, school-based mental health professionals, and community mental health providers. "There is often a misunderstanding of what everyone does or should be doing, even among professionals."

  – Encouraging schools to develop agreements with local authorities and other community providers to align care needs and ensure access to a broader continuum of care. The state could consider developing or promoting model language.

  – Creating systematic connections between community behavioral health providers and school-based mental health professionals. For example, multi-disciplinary teams could serve as intermediaries between schools and contract with (or have direct connections with) community behavioral health providers and/or DHHS.

  – Continuing to provide direct training and technical assistance to school-based mental health professionals, school counselors, and other staff. Note: some training efforts are already underway (e.g., suicide prevention training). These efforts have helped reduce stigma among school staff and future efforts include working with USBE to develop a document informing school professionals about appropriate suicide prevention screening methods. A concern related to this point is balancing this training with the increasing requests being placed on Utah's educators.

  – Implementing anti-bullying and life skills building programs in schools, particularly in lower grades (e.g., Dialectical Behavioral Therapy (DBT) skills training).

- Provide funding and support for more home visiting programs to address infant and early childhood mental health as well as provide family support (Figure 18). Some discussion groups noted they would like to see more home visiting programs available to new mothers, particularly families with high behavioral health needs or other risk factors.

- Provide funding and support to programs that address childhood trauma and ACEs including increasing public and private payers' coverage of these programs and ensuring they are reimbursed at sustainable rates.

- Create additional opportunities for implementing public-private partnerships with health organizations and foundations interested in supporting school-based services and the mental, emotional, and behavioral health of children and youth through programs and services that increase alignment between the public and private systems.

- Better integrate tobacco cessation and behavioral health treatment by:

  - Providing persons seeking tobacco cessation services with recommended resources related to managing or coping with stress and other mental health issues. Providing these resources could improve successful quit outcomes and the lives of individuals.[94]

  - Prioritizing and increasing awareness of tobacco cessation programs and Quit Line services to individuals in mental health and behavioral health treatment.

  - Integrating tobacco screening into behavioral health intake forms and recommending clients to either the Utah Tobacco Quit Line or other tobacco cessation services. Proven treatments, such as FDA-approved medicines and behavioral counseling, make it more likely people will quit smoking successfully.[95]

  - Providing tobacco cessation training to the behavioral health workforce, particularly peer support specialists, to increase usage of tobacco cessation services throughout the state.

  - Encouraging mental health and SUD treatment centers to create and maintain tobacco free campus policies and integrate tobacco cessation interventions into behavioral health treatment. This could decrease tobacco-related disease and death and improve behavioral health outcomes.[96]

PRIMARY CARE BASED BEHAVIORAL HEALTH

Provider-Level Integration

Primary care based behavioral health is the provision of mild-to-moderate behavioral health care in the primary care setting, which is often the first point of contact for patients with mental health and SUD needs. Providing behavioral health services in this setting creates more access, better integration of physical and behavioral health, and opportunities for early intervention—

preventing the escalation of behavioral health conditions and reducing crisis and emergency department (ED) utilization. Supporting primary care based behavioral health could also help alleviate the state's workforce shortages.

Gaps, Challenges, and Needs:

- *Limited screening and early identification of mental health and SUD.* Limited screening for mental health and SUD (particularly in pediatric practices) prevents early identification of behavioral health needs and the ability to connect individuals to appropriate care before more acute care is needed. Challenges to implementing screenings stem from:

  - Low or no reimbursement.

  - Lack of training supports and primary care staff capacity to engage in screening.

  - Requests from health systems, advocates, and other stakeholders to consider multiple, distinct screening tools (which may not be supported by reimbursement).

  - Not having appropriate training or resources to address the risk and protective factors that contribute to mental health issues and SUDs in the primary care or pediatric setting (e.g., trauma-informed training).

  - Lack of access to specialty care when referral is necessary.

  - Lack of system coordination, including relationships between primary and specialty care to support referrals, and technology to support closed-loop referrals to behavioral health services, stabilization supports, and wraparound services.

- *Insufficient reimbursement.* To be successful— and incentivize physicians to integrate behavioral health services into their practice—physicians need to be adequately reimbursed for providing mental health and SUD services in a primary care setting. Some examples of services that are not well reimbursed include behavioral health screeners (as noted above), patient coordinators, care managers, peer support specialists, etc.

- *Limited primary care-based SUD services.* While discussion groups acknowledged that primary care based mental health is improving, the provision of SUD services in a primary care setting is a gap in the system. This is due to limited prescribing providers across the state, particularly in rural areas where access to Medication Assisted Treatment (MAT) and Medication for Opioid Use Disorder (MOUD) is limited in both physician-based settings and in some jails for individuals who are incarcerated. [See "Gaps in Available Medication Assisted Treatment (MAT)" text box for more information.]

Bright Spots:

- *Local collaboration.* Local collaborations that strengthen provider-level integration currently occur between Utah's community health centers, local authorities, and public and private health systems. For example, Utah's community health centers (federally qualified health centers) screen all patients for depression as part of providing comprehensive preventive care. Patients identified as at risk are often managed within the health center by the center's behavioral health providers using integrated delivery models, such as Primary Care Behavioral Health and Collaborative Care Management. Patients identified with behavioral health needs that are beyond the capacity of the health center are referred to the local authorities as needed, with the health center continuing to offer medical services to these patients. Several health centers have co-location arrangements with local authorities, further enhancing the ability to co-manage the health of patients with more significant behavioral health needs. Some health centers also collaborate with their local hospitals to accept referrals of patients being discharged who require additional behavioral health care that would be optimally provided in a primary care setting.

- *The VA (Veterans Affairs).* The VA provides an integrated "no wrong door" approach to physical and behavioral health. Behavioral health services are integrated in the primary care setting through consultation and targeted referrals. Patients move fluidly through the system, receiving access to necessary physical and behavioral health services. That said, a Utah Rural Veteran Needs Assessment found that veterans in rural areas have a challenging time accessing necessary and appropriate services.[99] [See "Impact of Workforce Shortages on the VA" text box for more information.]

- *Utah's Indian health system (I/T/U).* A key strength of Utah's Indian health system is the traditional practice of integration of physical and behavioral health. This provides improved access to holistic services for Utah's American Indian/Alaska Native (AI/AN) populations and communities, particularly in Utah's rural and frontier areas where access to coordinated services is limited. Continuing to improve access to behavioral services, resources, and funding is a key priority for Utah's Tribal and the Urban Indian Health programs and the representatives of Utah Indian Health Advisory Board.

- *Intermountain Health Mental Health Integration (MHI) Model.* The Intermountain Health MHI model is a team-based, whole-person approach to meeting the physical and behavioral health needs of patients and their communities.

The focus is on patient engagement and shared decision-making, with care delivery led by the Primary Care Provider and supported by Care Management (Care Managers and Care Guides) and MHI Providers (i.e., licensed clinical social workers (LCSWs), psychologists, APRNs, and psychiatrists). "It's been such a blessing for so many people to see collaboration among their mental health [providers] and medical doctors." Intermountain is also implementing the Collaborative Care Model.

- *Expanding coverage and implementation of Collaborative Care.* Utah Medicaid, Medicare, TRICARE, PEHP, and several other private health insurance plans in Utah reimburse for Collaborative Care codes. As a result of this coverage, as well as increased education about the Collaborative Care Model, some providers in Utah are beginning to develop the neces-

sary infrastructure to support the model and bill the codes. For example, several of Utah's community health centers utilize the Collaborative Care Model and the University of Utah recently launched its Collaborative Care initiative. [See "Collaborative Care Model" text box for more information.]

- *Federal legislation.* Pending federal legislation (H.R. 5218) would incentivize primary care providers' uptake of the Collaborative Care Model.[100]

Suggested Ideas for Next Steps:

- Provide better training to primary care practices on the provision of mild-to-moderate behavioral health treatment (participants noted that behavioral health training for physicians is often limited, e.g., 4-6 weeks). Discussion groups suggested:

  – Promoting or implementing uniform screeners across the system.

  – Providing more education and appropriate tools to pediatricians on how to recognize and diagnosis mental health needs in young children (e.g., DC:0–5™ the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood).

  – Providing training to behavioral health clinicians working in integrated clinics on how to provide brief physical health interventions and therapies.

- Improve physician support. Integrating behavioral health services in the primary care setting is a major process. "Primary care [physicians] can't do it all in a 15-minute visits." Specific ideas mentioned during the discussion groups include:

  – Developing and expanding technical assistance support for providers working to implement integrated or team-based approaches.

  – Developing enhanced referral networks to support primary care providers with screening and early identification and create connections to behavioral health providers for patients with complex behavioral health needs or chronic behavioral health conditions.

  – Continuing to provide statewide consultation support to primary care providers (e.g., the Psychiatric Consultation Program, or CALL-UP[103]).

  – Provide state-supported education, training, and technical assistance to primary care providers to invest in the Collaborative Care Model. Primary care collaborative models can be difficult to establish but have the potential to reduce the need for crisis and more acute services in the long term.

Collaborative Care Model

Collaborative Care is an evidence-based model of behavioral health integration that treats common mental health conditions such as depression, anxiety, and SUD. Primary care providers work with embedded behavioral health professionals (who can be unlicensed providers) to identify and treat behavioral health conditions with evidence-based brief interventions, care management supports, and use of a consulting psychiatric provider to improve primary care medication adjustment for patients who are not improving.[101] Collaborative care uses evidence-based treatment and tracks patient populations in a patient registry.

More plans are covering the Collaborative Care codes, but provider uptake is low despite this being a key initiative for the state.

Impact of Workforce Shortages on the VA

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

Interestingly, a recent study found a greater presence of highly trained specialists treating veterans in the VHA compared with providers treating veterans in the community (22% vs. 10% of psychiatrists and behavioral neurologists and 25% vs. 18% of psychologists). The VHA also had a greater presence of social workers (36% vs. 15%).[102]

INTEGRATED PHYSICAL & BEHAVIORAL HEALTH CARE

Payer-Level Integration

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

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

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

Gaps, Challenges, and Needs:

- *Payer-level integration of physical and behavioral health:* A common theme among the different discussion groups was the challenges stemming from lack of physical and behavioral health integration. Examples of issues and concerns include:

  – The inability for providers to treat co-occurring physical and behavioral health issues.

  – Challenges for care management when an individual has separate payers for physical and behavioral health, often resulting in gaps in service information essential to support whole person approaches and coordination of care across providers.

  – The inability for patients to receive mental health and SUD services during a physical health visit, which creates barriers to access, increases the potential for two co-pays, and reduces the ability for the system to establish a "no wrong door" approach to care.

  – Lack of system-level coordination (Utah Medicaid ACOs cover medication management, county health departments oversee prevention-related activities, different state and federal funding sources for SUD vs. mental health services, etc.). [See "Administrative Challenges Related to Data Reporting" text box for more information.]

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

- *Mixed opinions on the effectiveness of the Utah Medicaid Integrated Care (UMIC) program.* The goal of the UMIC program is to increase payer-level integration in Medicaid. The program started January 1, 2020, and care is managed through integrated ACOs in five counties. Discussion groups had mixed opinions on its effectiveness. For example:

  – Several groups expressed concerns with the program, including: (1) Lack of data sharing between the ACOs and the local authorities and other providers, which limits their ability to coordinate care, manage services, and provide critical wraparound services for the SMI population (Figure 19). (2) ACOs not having necessary experience caring for the SMI population. (3) Changes in the administration of funding, which reduces the ability of local authorities to sustain the provision of critical crisis services, wraparound services, and community partnerships. (4) Reimbursement structures that do not account for SMI populations' treatment needs. (5) Burdensome procedures related to credentialing, reporting, and documentation requirements, billing, service denials, and prior authorizations.
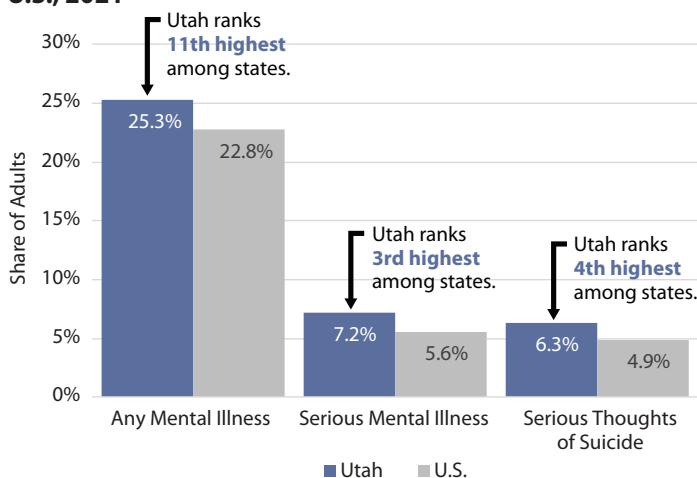
"The SMI population needs a behavioral health home."

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

- *Continuity of care in Medicaid.* Another concern is the issue of "churn"—individuals moving between different Medicaid programs, different ACOs or prepaid mental health plans (PMHPs), and on and off Medicaid. This churn and changing eligibility disrupt a person's continuity of care. For example, a

Figure 19: Adult Mental Health Indicators in Utah and the U.S., 2021

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

person who moves from the Targeted Adult Medicaid (TAM) program, which is administered by the Medicaid agency, and into a different Medicaid program could have to access a different provider network and set of behavioral health services. An individual moving from public to private health care coverage would likely experience similar issues. The discontinuity created by churn is particularly difficult for individuals who are unhoused and individuals whose income just barely exceeds the levels necessary to qualify for the TAM program. These individuals lose access to the additional services and supports the TAM program provides (e.g., continuous eligibility and housing-related supports).

Bright Spots:

- *Medicaid continuous coverage of the Targeted Adult Medicaid (TAM) population*. The TAM program provides Medicaid services to a capped number of adults without dependent children who are: (1) chronically unhoused; (2) involved in the criminal legal system through probation, parole, or court ordered treatment needing substance abuse or mental health treatment; and (3) needing substance abuse treatment or mental health treatment. The TAM program offers beneficiaries 12 months of continuous coverage. [See "Utah's Behavioral Health Delivery Workgroup" text box for more information.]

Suggested Ideas for Next Steps:

- Consider establishing 12-month continuous eligibility in Medicaid to prevent people from switching programs more than necessary. Twelve-month continuous eligibility guarantees Medicaid coverage for 12-months despite changes in income or other circumstances. "It is very confusing for patients to be dropped from Medicaid every six weeks [for eligibility redetermination]."

- Continue to study policy, program, or statute changes to reduce barriers created by the state requirement that Utah's county governments match Medicaid behavioral health services.

- Engage in further evaluation of the UMIC program to address challenges providers currently experience related to timely reimbursement and burdensome procedures (e.g., credentialing, billing, service denials, and prior authorizations). Consider ways to improve public accountability, ensure transparency, and increase provider sustainability.

- Consider establishing shared system incentives for achieving positive outcomes to encourage continuity of care both within Medicaid and between Medicaid and other payers.

OUTPATIENT SPECIALTY SERVICES

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

Gaps, Challenges, and Needs:

- *Limited access.* The lack of access to outpatient specialty services stems from a myriad of issues, including more people needing behavioral health services due to the state's rapid population growth, Medicaid expansion, lessening stigma, improved access to crisis services (i.e., receiving centers and MCOT teams), workforce shortages (worsened by the COVID-19 pandemic), administrative burdens, limited reimbursement, lack of system coordination, and the creation of system siloes. The following are examples of gaps in outpatient specialty services mentioned in different discussion groups.

  While these gaps are listed in the outpatient specialty services section, many extend to all areas of the behavioral health services and supports continuum.

  - Psychiatrists.
  - Rural-area providers (need spans all specialties).
  - Tribal area providers (need spans all specialties). Some participants also noted the desire for continued extension of the "four walls" grace period that allows Tribal, IHS-operated, and state facilities to provide clinic services outside of the "four walls" of a facility[104] and for Medicaid to reimburse for more culturally responsive, but non-traditional behavioral health services such as traditional healing practices. [See "Medicaid Coverage of Traditional Healing Services" text box for more information.]
  - Language accessible and culturally responsive providers, representative of different communities and populations, with a focus on Spanish-speaking therapists and interpreter services.
  - Providers who are qualified to treat persons with co-occurring conditions, with a focus on ID/DD and ASD. Note: Reimbursement for these services come from different funding streams and state agencies, which creates challenges in developing and sustaining this workforce.
  - Therapists who accept court-ordered treatment (resulting in a current backlog of juvenile court cases). Note: private health insurance plans may place limits on the number of covered sessions, which could impact a person's ability to complete court-ordered treatment.
  - Providers who are qualified to treat persons who are unhoused (including peer support specialists and certified case managers). "Individuals who are unhoused face insurmountable barriers simply meeting their survival needs, let alone the ability to engage in treatment above and beyond these needs." "Individuals who are unhoused shouldn't have to end up in the criminal legal system to get support."
  - Providers who are qualified to treat geriatric behavioral health, including intensive outpatient programs (IOP), and providers who are qualified to treat early childhood, child, and youth behavioral health issues.
  - Assisted Outpatient Treatment (AOT) due to limited reimbursement.
  - Providers who are qualified to treat persons with eating disorders. [See "Eating Disorders" text box for more information.]

A few participants also mentioned a desire for more providers trained in treatment modalities such as nutrition therapy, ketamine, Eye Movement Desensitization and Reprocessing (EMDR), psychedelic-assisted therapy, and transcranial magnetic stimulation (TMS).

> ### *Medicaid Coverage of Traditional Healing Services*
>
> Three states currently have 1115 waivers pending CMS' approval that request Medicaid coverage of traditional healing services (New Mexico, Arizona, and California).[105] Arizona's waiver, for example, would allow the Indian health system (I/T/U) or the tribal governing body to define the qualifications of traditional healers and the scope of services reimbursable under Medicaid. Expanding Medicaid reimbursement to traditional healing services provided by healers could help address workforce issues, improve access, and increase the availability of culturally appropriate services to Utah's American Indian/Alaska Native populations.

Eating Disorders

Anorexia nervosa has the 2nd highest mortality rate of any psychiatric disorder.[106] Discussion group participants noted they've seen a recent rise in the prevalence of eating disorders in Utah, potentially driven by increased use of social media by young adults and teens.

Discussion groups also noted the limited availability of services for persons experiencing eating disorders, particularly community-based outpatient services. This creates barriers to discharging patients with eating disorders from acute or residential settings (and emergency departments) and supporting them with services provided in their community. Many outpatient mental health providers do not have the necessary training to treat eating disorders effectively.

To better prevent and address eating disorders in Utah, discussion group participants recommended improved screening in pediatrician and primary care offices, improved community and school-based education, better training for pediatricians and primary care doctors on identify and addressing eating disorders, and improved reimbursement for eating disorder services across all payer types to incentivize more mental health providers to receive the necessary training and qualifications to treat eating disorders.

More information on Eating Disorders Among Utah Women is available from:

https://www.usu.edu/uwlp/files/snapshot/45.pdf

- *Quality and outcomes:* As noted above, some studies estimate that only 40% of persons receiving behavioral health care benefit from the treatment received.[107, 108] As also noted above, discussion group participants want to feel that "recovery is possible." Having access to high-quality and evidence-based services, supports, and interventions can help people achieve recovery. That said, moving high-quality, evidence-based treatment into routine practice is difficult and there are practical and preferential barriers to implementation, including time and resources. One study shows that it takes nearly two decades to move less than 14% of evidence-based research into practice.[109] Continuing the use of valid and reliable measures that are already in use (Outcome Questionnaire, Functional Outcome Survey, Brief Addiction Monitor, Substance Use Recovery Evaluator (SURE), etc.) provides an opportunity to scale measurement-based care and improve safety and outcomes within an existing infrastructure that can be expanded in the future.

- *Restricted choice.* Some discussion groups also mentioned a need for more choice when accessing outpatient specialty services. Challenges related to "choice" seem to stem from lack of coverage. For example, a few groups expressed concern that some public and private payers do not contract with community providers. This limits access and choice— particularly to providers that may have more expertise in treating individuals from diverse cultures and communities.

- *Navigating the complexity of private health insurance coverage and reimbursement of behavioral health services.* The complexity of navigating private health insurance plans, both from a provider and patient perspective, contributes to challenges with access and choice. For example, the fact that different plans cover a wide range of different services, impose different coverage restrictions, and negotiate different costs, makes it difficult for patients to navigate the system and for providers to make appropriate referrals and provide transition supports (particularly when a patient is in crisis). Individuals with HDHPs may more acutely feel lack of choice, given they are paying more out of pocket for behavioral health services. [See "Behavioral Health Issues are Not Acute Health Issues" text box for more information.]

- *Sustainable funding.* In addition to better access and more choice, outpatient services need more funding and support. Many community-based providers, particularly those that serve diverse cultures and communities, currently use grant dollars to support their operations and services but must figure how to sustain these operations once the grant funding ends. Many of these providers are also nonprofit organizations that do not have the capacity or resources to handle the increasing demand they currently experience. Higher reimbursement and/or alternative payment methodologies that provide sufficient reimbursement for a variety or bundle of services (from both public and private payers) could help sustain these services and improve access to care. "Grants, legislatively appropriated funding, and federal funding are not sufficient to support the current need for behavioral health services in Utah."

- *Services for Persons with Co-Occurring Conditions.* Many of the discussion groups mentioned improving access to services across the behavioral health continuum for individuals with co-occurring conditions, particularly ID/DDs. The need spans from those with lower acuity conditions—who can and want to be seen in the community—to those who need inpatient or residential care. In both situations, these individuals may need access to different spaces and treatment techniques, which can

be difficult for facilities to accommodate. As a result, these individuals can be denied care and have a difficult time accessing the treatment they need. This unfortunately gives the perception that behavioral health providers are unwilling to treat people with additional disabilities or co-occurring conditions. [See "30–50% of individuals with an ID/DD have a co-occurring mental health diagnosis" text box for more information.]

Behavioral Health Issues are Not Acute Health Issues

There is a need to recognize that behavioral health issues often cannot be treated and reimbursed like acute care issues. Doing so leaves the patient/consumer paying for services out of pocket or places the burden on the public system to find ways to provide underinsured individuals with ongoing services and supports if the person cannot pay.

However, Coverage Seems to be Improving

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

- *Services for persons who are incarcerated.* Discussion groups also mentioned the need to improve access to behavioral health services for individuals who are incarcerated. These discussions primarily focused on:

  – Improving continuity of Medicaid coverage and data sharing between Medicaid programs. Note: federal regulations limit the coverage Medicaid can provide while someone is incarcerated. As such, alternative sources of funding may be needed to ensure access and continuity of care while individuals are incarcerated.

  – Eliminating the delay individuals leaving prison experience before enrolling in Medicaid (which can be up to 30–45 days). One of the biggest barriers is the waiting period required after a person is released from prison and placed on parole.

  – Improving data collection to help ensure continuity of services. For example, the state currently has an agreement with the University of Utah that persons leaving jail can access Medicaid-covered services at University of Utah hospitals and clinics. Problems arise, however, with individuals who cycle in and out of correctional facilities making it difficult to connect them to follow-up care. Information is also self-reported, which results in missing information.

  – Improving funding to sustain and expand effective, evidence-based programs that reduce recidivism by addressing behavioral health needs (e.g., Salt Lake County's Life Skills and CATS (Correctional Addiction

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"30–50% of individuals with an ID/DD have a co-occurring mental health diagnosis".[110]

While people with ID/DDs make up about 1% of the U.S. population, they are disproportionately impacted by mental health issues. Rates of ID/DD also increase with age. About 10% of Utah adults have a cognitive disability.[111] Concerns related to access for this population include:

- DSPD's current waitlist. There are almost 5,000 people currently on DSPD's waitlist.[112] The average wait time was 5.5 years in 2022.[113] Individuals on this waitlist often have accompanying mental health issues or SUDs but they are unable to stabilize without the ability to concurrently receive DSPD services. As a result, they "frequently bounce through systems, including the criminal legal and homeless systems, adding costs to these systems and the taxpayer."

- There was also concern about how the waitlist prioritizes people based on need. Some higher-functioning

individuals, particularly adults, are left with no access to services.

- Caps on Medicaid waiver participation and funding for persons with disabilities.

- Private health insurance plans often do not reimburse for services related to ID/DDs and only some services related to ASDs (for children ages two to nine).[114]

- There is lack of services for elderly and other patients with dementia that have co-occurring behavioral health issues.

- An area for further exploration is whether the need for these services is due to the lack of behavioral health services or unmet need through DSPD (i.e., what type of service is most needed, behavioral health or ID/DD-focused).

Treatment Services) programs). For example, discussion groups estimated that if AP&P Treatment Resource Centers[115] billed Medicaid for services (and leveraged Medicaid's federal participation), it could save 60-70% of their state general fund dollars.

Bright Spots:

- *SUMH's multi-cultural affairs grant.* SUMH provided over $1 million in grants to community organizations. This funding allowed grant recipients to expand services, including medication and wraparound services such as childcare. SUMH provided technical support to grant applicants and worked closely with recipients to co-create solutions tailored to their specific populations and needs. More funding (both funding amount and number of funding opportunities) like this is needed to help sustain the system—funding that is flexible, comes with technical assistance, and adheres to best practices.

- *Flexible reimbursement.* In addition to flexible funding provided through SUMH's multi-cultural affairs grant, some local authorities are working to provide reimbursement when a patient is a no-show. The lack of reimbursement for no-shows is particularly difficult for nonprofit and community providers who serve diverse cultures and communities. Many of these patients require interpreter services, which must be paid for even if a patient does not make their appointment.

- *Targeted Adult Medicaid (TAM) program.* Utah is engaged in a Justice Reinvestment Initiative (JRI),[116] designed to keep low-level offenders out of prison. Part of this process requires funding to expand community behavioral health treatment to help divert re-offenders and connect them to treatment. However, while JRI passed in 2015, the intended funding mechanism for treatment (Healthy Utah, one of the Medicaid expansion plans), did not pass the Utah House. The local authorities instead received limited dollars, meeting only a fraction of the need. The Utah Legislature appropriated additional dollars in 2016, which continued to serve only a portion of the population involved in the criminal legal system.

  As such, the TAM waiver, approved in 2017, became the largest payer for individuals in the criminal legal system who have an SUD as the primary condition. This funding allowed community treatment providers to significantly expand SUD treatment capacity in Salt Lake County (Figure 20), while also expanding other levels of care (the program is based in fee-for-service, meaning it is open to "any willing provider"). As noted above, the waiver allows an individual to remain eligible for a one-year period and allows for Medicaid reimbursement for SUD services provided in programs with more than 16 beds (i.e., an IMD waiver). The TAM program received national recognition.

- *1115 waiver: Medicaid Coverage for Populations in the Criminal Legal System.* The state is evaluating possible updates to a 1115 waiver pending approval from the Centers for Medicare & Medicaid Services (CMS) that would allow Medicaid coverage 30-days prior to an individual being released from a correctional facility. Individuals must have a chronic physical or behavioral health condition, a mental illness as defined by Section 62A-15-602 of Utah State Code, or an OUD.[117] Having coverage prior to release would eliminate the waiting period referenced above and help reduce the lag time between when a person's application is approved and when they can start accessing services (retroactive eligibility). Expanding eligible populations to include a broader set of SUDs could also help improve access.

Suggested Ideas for Next Steps:

- Seek legislative support for a Medicaid data management system to help improve access to services for persons who are incarcerated.

- Encourage employees with HDHPs to contribute more to HSA/flexible spending accounts and provide education on the access points and costs related to behavioral health services.

- Increase behavioral health safety-net funding. Establish a legacy fund that could grow in perpetuity and support high-need areas.

- Incentivize businesses to focus on behavioral health. By helping businesses understand the importance of behavioral health, they will seek health insurance plans that cover a broader range of behavioral health services.

- Establish more behavioral-health focused value-based or alternative payment models (can help address reimbursement issues experienced across the continuum of care).

- Develop a forum or coalition for private health insurance companies to discuss behavioral health issues (e.g., a subgroup or group connected to the Utah Health Insurance Association, UHIA). Health plans could benefit from a collaborative and aligned approach to behavioral health. Developing a collaborative path forward could hopefully reduce the need for legislative mandates, which negatively impact private health insurance plans and push more employers into self-funded plans. The collaborative could promote a common approach to physical and behavioral

Figure 20: Changes in the Number of People Enrolled in Substance Use Treatment in Utah, 2015-2017 and 2019
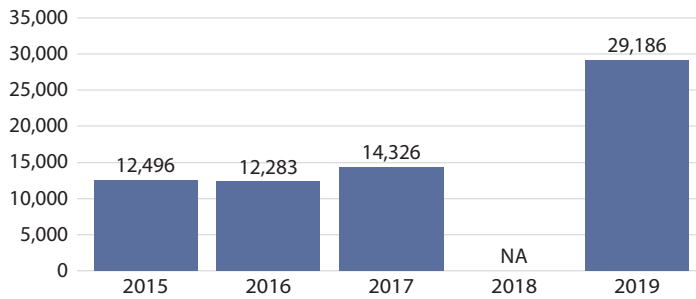
Source: Behavioral Health Barometer Utah, Volume 6. (2020). Substance Abuse and Mental Health Services Administration.

health integration efforts as well as help drive the use of value-based payment models.

• Promote evidence-based treatment. Some discussion groups noted that the way to improving care quality is finding ways to measure improvement and focus on recovery. Others suggested developing an outcomes dashboard. This could help ensure evidence-based practices are adopted with fidelity. Others noted that providers who engage in evidenced-based practices "should be prioritized and paid more."

CRISIS/DIVERSION SERVICES

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

Gaps, Challenges, and Needs:

• *Rural-area crisis services:* Many rural area participants expressed a desire for more crisis/diversion services. Even with the statewide expansion of MCOTs, the difficulties of deploying, accessing, and sustaining MCOTs in Utah's rural and frontier areas, including long wait times, distance and barriers created by geographical terrain, and limited staffing. For example, these services typically need to be available 24/7, which results in a high average cost per crisis, but the avoided cost of police involvement and emergency care is not recognized when calculating direct costs.

• *Sustaining crisis and diversion services.* Crisis and diversion services could benefit from more alternative payment methodologies. For example, Medicaid reimburses receiving centers through a lump sum or bundled payment,

while private health insurance plans reimburse for discrete services. The bundled payment better encompasses a variety of necessary services and allows for more flexibility, which is important when addressing patients with a variety of crisis needs. Participants also noted a need to create pathways for sustainable funding for recovery community organizations and other recovery-focused nonprofit organizations outside of Medicaid or health insurance reimbursement.

• *Receiving, access, and other crisis/holding centers.* The lack of receiving centers in Utah's rural areas places a heavy burden on law enforcement as well as reduces the ability to divert individuals to appropriate behavioral health services. Police officers in rural areas often take people to the ED, which requires police monitoring. The time this takes, coupled with an increase in behavioral health-related incidents, is negatively impacting law enforcement's ability to serve the community and engage in other activities.

• *Social detox services/facilities.* A few discussion groups noted the need for more social detox and other types of ambulatory withdrawal management services. These programs engage individuals when care is most needed and move them to appropriate levels of longer-term or higher-acuity care. That said, many of these programs and services are not supported by private health insurance plans and are unaffordable for most persons. This makes it difficult to provide these services in smaller communities. Discussion group participants were also confused about what components of social detox services are covered by Medicaid. Finally, it was noted many residential centers cannot take patients in withdrawal, meaning individuals are unable to access care unless they can show evidence of being sober.

• *Lack of coordination with the criminal legal system.* Utah's court system is using the Sequential Intercept Model (SIM)[118] to understand how individuals with mental health and SUD intercept with and move through the criminal legal system. Utah's courts currently get involved with treatment when individuals enter jails/courts (intercept 3) but would like to see offenders engage in treatment at earlier levels. The biggest gap in diversion resources exist at the community, law enforcement, and initial court hearings/detention levels (intercepts 0, 1, and 2). Funding also often only attaches to higher levels (jails/courts, reentry, and community corrections). As a result, the court system needs better access to upstream services and existing diversion services.

• *Training and education of law enforcement.* In general, discussion groups perceive that law enforcement needs to be better educated about mental health episodes and

SUDs. This is particularly true for defendants who commit low-level offenses, adults with cognitive impairment and other infirmities, and individuals with high behavioral health needs (e.g., individuals who cycle through jails, homeless shelters, and EDs and require mental health services). While receiving centers and MCOTs have helped address some of these issues, participants noted that many mental health cases still end in arrest. For example, mandatory arrests for domestic violence offenses may encourage families not to call the police because they do not want an arrest to be made. There also needs to be better standards when it comes to "pink sheeting," or detaining an individual for the purpose of emergency hospitalization. A consistent set of standards for "pink sheeting" or how law enforcement engages with mental health episodes and SUDs is not used across the state, meaning the decision is often left to the police officer on duty. That said, groups like the Crisis Intervention Team Utah—that provide best-practice certification and training—are working to bring together law enforcement, mental health professionals, and mental health advocates to improve community responses to mental health crises.[119]

Bright Spots:

* *Current and ongoing development of receiving centers and the expansion of MCOTs.* Discussion groups noted improvements to the state's crisis and diversion services with the establishment of the receiving centers and MCOTs. Participants appreciated the safe space they provide people experiencing mental health and SUD crises. Participants also appreciated that some of the receiving centers are being developed with input from those with lived experiences and felt that more of this input is needed in the development of behavioral health services and supports.

* *Establishment of 988 and the Utah Behavioral Health Crisis Response Commission.* 988, a nationwide 3-digit number for mental health crisis and suicide prevention services, went into effect in July 2022. S.B. 155 (2021) established Utah as a leader in these efforts by creating a 988 restricted account for funding related activities, requiring the Division of Medicaid and Health Financing to adopt or apply for a state plan amendment or waiver to support crisis services (including the crisis line), and adding additional members to the Crisis Response Commission. The commission is currently developing recommendations for expanding Utah's crisis system in a way that is designed for anyone, anytime, and anywhere. Key goals include better care, hospital diversion, and law enforcement/jail diversion.

Suggested Ideas for Next Steps:

* Provide more education and awareness of crisis and diversion services. This could include promoting crisis resources as well as training law enforcement and related agencies on the availability and details of MCOTs and receiving centers (e.g., a referral is not needed).

* Address rural area crisis/diversion service challenges. Possible solutions include: (1) considering alternative models by leveraging telehealth or co-location with rural-area hospitals or providers (participants mentioned that previous telehealth-related proposals did not gain traction due to limited reimbursement); (2) using social workers and peer support specialists to assist with more crisis situations; and (3) considering alternative payment models to help sustain both rural and urban area crisis/diversion services.

* Connect the state's court system to existing prevention and diversion services and ensure sufficient services are available for the court system, particularly rural-area courts.

* Develop consistent payment sources for funding, sustaining, and expanding crisis/diversion services across the state.

SUBACUTE CARE, ACUTE/INPATIENT CARE, AND RESIDENTIAL CARE

For purposes of this report, subacute care includes a variety of long-term services and supports provided in a non-acute hospital, facility, or community-based setting for people recovering from an acute behavioral health condition. Examples of such services and supports extend from community to facility-based settings and include assertive community treatment (ACT) teams; caregivers for cognitively impaired older adults; withdrawal management and detox services; residential, partial hospitalization, and other intensive outpatient services; community-based recovery services and supports; and subacute hospital care.

A common theme among discussion groups was the need for more subacute care options—both across the state and especially in rural areas. This gap in the continuum exists both in front of and behind acute inpatient care.

This section also provides information on acute/inpatient care, including residential, since many of the gaps, challenges, and needs are interconnected. Acute/inpatient care is defined as inpatient behavioral health treatment and stabilization. [See "Acute/Inpatient Facilities" text box for more information.]

Gaps, Challenges, and Needs:

- *Fixing the front end.* A predominant theme among discussion groups is the lack of services for individuals needing more than crisis and diversion services, but something less than acute or inpatient care. For example, some of the discussion groups noted the lack of services that exist between receiving centers and inpatient care, or between social detox and inpatient care. Existing programs' capacity is also insufficient for the state's growing needs. Rural areas lack access to "step up" services, particularly for individuals that do not meet State Hospital criteria, but have higher acuity needs than what can be provided in the community. [See "Step-Down Services" text box for more information.]

Step-Down Services

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

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

Acute/Inpatient Facilities

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

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

- *Fixing the back end.* Another predominant theme is the lack of "step down" services or intermediate care facilities for people moving away from high-acuity, inpatient care, but who need more than what is available through outpatient or community services in their area. It is important to note that the lack of appropriate step-down care and community-based resources and facilities contributes to the capacity issues experienced by inpatient care facilities as it delays their ability to discharge patients.

- *Long-term recovery.* The lack of step-down services also prevents long-term recovery. If no step-down services are available upon discharge, many patients experience a return of acute symptoms resulting in a return to higher levels of care. Discussion groups generally agreed that most patients are best served in their community, but this least restrictive approach (e.g., avoiding hospital or institutional-level care when possible) is only viable if services are available.

- *Low reimbursement and limited coverage.* Several groups noted that a main barrier to creating and sustaining subacute, acute/inpatient, and residential services and facilities is how they are governed and reimbursed. Participants discussed: (1) Medicaid reimbursement being too low; (2) federal regulations limiting reimbursement for IMDs being too restrictive; and (3) private health insurance plans imposing limits on services and reimbursement. Specific examples of issues and concerns include:

  – Reimbursement and coverage variability across payers dictating treatment quality. Payers changing contract terms without notice also makes it difficult to provide consistent care.

  – Limits on coverage resulting in treatment disruptions. For example, a person may be discharged from residential care sooner than they should due to their health plan's coverage limits. This restricts their ability to stabilize in a residential or acute care setting. Constant utilization reviews are also disruptive.

  – Limited-to-no funding being available to support unfunded or uninsured populations. "We haven't raised our self-pay rate in 10 years."

  – Patients' acuity levels not aligning with payment. "Medicaid and TAM pay a quarter of what commercial health insurance does."

  – Low Medicaid reimbursement making it difficult for acute, inpatient, and residential care facilities to operate with sufficient margins, which disincentivizes new facilities from entering the market. Some facilities

located in Utah do not provide services to Utah residents. "Utah has the most residential beds per capita but least access to those beds."

– Medicaid covering treatment provided in an acute, inpatient, and residential setting, but not room and board. Some SUD federal block grants can help cover room and board, but reimbursement is difficult.

– Burdensome procedures related to credentialing/ paneling, billing (e.g., exclusions on same-day billing), service denials, reporting and documentation requirements, and prior authorizations. That said, it is important to note that health plan policies are designed to help ensure members receive effective, evidence-based treatments, have access to high-quality providers, and avoid fraud, waste, and abuse. To maintain safety and quality services, addressing this issue should focus on streamlining administrative complexities and easing unnecessary burdens.

Bright Spots:

• *Increased capacity at the Utah State Hospital.* H.B. 35 (2020) provided funding to open 30 additional beds at the Utah State Hospital. The state pulled back this funding during the COVID-19 PHE but reinstated it in 2022 and the beds are scheduled to start opening in November 2023. The state also authorized increased pay for Utah State Hospital staff, which helped address some of the hospital's workforce needs.

• *Utah Medicaid IMD waivers.* CMS approved the state's SUD and opioid services IMD waiver in 2019. This waiver allows Utah Medicaid to reimburse SUD residential treatment centers with more than 16 beds.[120] H.B. 219 (2020) required the state to submit a mental health IMD waiver, which would also allow Utah Medicaid to reimburse mental health residential treatment centers with more than 16 beds for stays less than 15 days. CMS approved the waiver in 2020. Participating entities are required to receive accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission. As noted above, some discussion group participants indicated a desire for more flexibility from CMS regarding restrictions in the mental health IMD waiver.

• *Increasing step-down or interim care facilities.* The state is currently exploring how to incentivize some nursing home facilities to provide step-down or interim care for state hospital and other patients who require long-term custodial care. This includes examining how to provide this benefit to Medicaid enrollees, whether and what level of appropriation would be required, obtaining CMS approval, and how to expand these types of services to group homes.

• *State Hospital long-term care facility.* The state is also exploring the development of a long-term facility at the Utah State Hospital that could serve both forensic and NGRI (not guilty by reason of insanity) populations that require lower-level acuity services but cannot be discharged into the community. The model is based on a facility in New Mexico and would be "a more structured community-based-like setting." It would be state funded, but not certified for Medicaid or align with the IMD waiver.

• *HMHI HOME Program.* The Neurobehavioral HOME Program (Healthy Outcomes, Medical Excellence) at the University of Utah is an outpatient clinic that provides mental and physical health services to Medicaid enrollees who are dually diagnosed with a developmental disability and a mental illness.[121] The program blends 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.

• *Assertive Community Treatment (ACT).* Several local authorities and other behavioral health organizations in Utah offer ACT, which is a national, evidence-based service delivery model that supports persons with high acuity mental health or SUD needs with activities of daily living. This includes providing integrated mental health and SUD treatment as well as other wraparound services such as managing finances, finding and maintaining stable housing, and maintaining health care appointments. ACT teams are community based and strive to provide services whenever and wherever clients need them.

Suggested Ideas for Next Steps:

• Address the Mental Health IMD gap and improve per-diem rates. This could include first establishing continual inflationary adjustments for Medicaid behavioral health rates. Beginning July 1, 2022, S.B. 161 (2021) requires an inflationary increase for Utah's Medicaid PMHPs. DHHS is currently evaluating whether state statute amendments are needed to include Medicaid behavioral health funding in the Medicaid consensus process (this process considers caseload growth and changes in the Federal Medical Assistance Percentages, FMAP). Additional clarification may be needed for this recommendation to be fully realized.

• Encourage additional value-based care arrangements, shared risk models, and bundled payment arrangements to help sustain community-based subacute levels of care. [See "Need for More Community-Based Services" text box for more information.]

- Consider establishing mental health crisis respite homes. These "homes" exist in residential settings and provide short-term crisis services. An example model are the homes established by the Georgia Department of Health and Developmental Disabilities. "Each home serves up to four individuals who are experiencing an emotional/behavioral change and/or distress that leads to a disruption of essential functions. Placement in Crisis Respite Homes occurs when individuals have not responded to less restrictive crisis interventions."[122]

- Develop an independent review board to manage concerns providers have with private health insurance plans related to subacute, acute, inpatient care, and residential behavioral health care coverage and reimbursement.

- Develop a HOME program or similar model specifically for geriatric patients.

STABILIZATION SUPPORTS AND WRAPAROUND SERVICES

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

Gaps, Challenges, and Needs:

- *Care coordination, transition support, and patient navigation.* As noted above, findings from the environmental scan indicate a strong need to improve system-level coordination, which is a key contributor to the state's challenges with establishing and maintaining effective care coordination, transition support, and patient navigation systems. These systems help providers make appropriate and timely referrals (both within and across systems), assist with care transitions, and engage in discharge planning (e.g., provide warm hand-offs)—as well as support patients in navigating the system.

- *Housing.* Nearly all discussion groups noted that there are insufficient housing vouchers, available and affordable housing inventory, and other assistance to address the state's growing housing needs. And while Utah's local authorities, community-based behavioral health providers, and other service organizations provide critical housing support services, they operate with limited resources in an increasingly expensive housing market with little housing stock. Additionally, Utah lacks the availability of permanent supportive housing to address the needs of its most vulnerable residents who are unhoused and have additional needs related to behavioral health.

The lack of affordable housing, permanent supportive housing, and housing support services is disrupting care across the behavioral health continuum—impacting patients and providers. For example, the issue:

  - Creates stress and instability that negatively impacts a person's behavioral health and well-being.

  - Limits the ability for the system to support care transitions along the continuum such as discharging patients from hospital stays or other high levels of care.

  - Increases the number of individuals who are unhoused and lengths of stay in shelters, community group homes, recovery centers, and other temporary or transitional programs. This exacerbates challenges related to "step-down" care and the ability to discharge patients from acute/inpatient settings.

  - Prevents people in the criminal legal system from effectively participating in court-ordered treatment.

  - Exacerbates the state's existing behavioral health workforce shortages. Behavioral health systems across urban and rural areas noted that they are unable to attract talent to their areas due to the lack of homes that are affordable.

- *Other supportive services.* In addition to housing, other gaps in supportive services include:

  - Case management, family peer support, and therapeutic behavioral health services (e.g., skills training).

  - Transportation, particularly in rural areas (e.g., a trip to a hospital could be 200-300 miles in some of Utah's rural areas). Discussion groups also noted a need for better

referral systems in rural areas given many referrals are not made to the closest option.

– SUD-specific supportive services, including drug prevention programs, syringe exchanges, naloxone distribution, other harm reduction efforts, etc.

- *Low reimbursement and limited coverage.* Coverage and reimbursement for supportive services is limited or non-existent. Specific areas mentioned by discussion groups that need better coverage and reimbursement include discharge planning, case management (Medicaid currently reimburses targeted case management for adults with SMI, children with SED, and individuals with SUDs),[123] peer supports, family peer support services, and therapeutic behavioral health services. "The system needs to provide coverage for the full continuum of care, just not acute care issues."

Bright Spots:

- *Utah's 1115 waiver covers housing services and supports.* Utah recently secured CMS approval for a five-year renewal of its Medicaid 1115 waiver, which will be in place through June 30, 2027. This waiver allows the state to provide housing-re-lated supports and services to the TAM population.[124] Hous-ing-related services and supports include tenancy support services, community transition services, and supportive liv-ing and housing services.[125] It's important to note, however, that this waiver doesn't address housing stock, affordable housing, or increasing home prices and interest rates. "We have many patients who have had housing vouchers for months and just can't find a place that is willing to take the voucher." "Having as many voices as possible in the housing conversation is critical to getting the resources needed in communities to develop more access to affordable housing."

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

services, housing, family support services, and respite services), consultation and education services (including case consultation, collaboration with other county service agencies, public education, and public information), and psychosocial rehabilitation (including vocational training and skills development).

Suggested Ideas for Next Steps:

- Expansion of certified or credentialed non-licensed care team members such as certified case managers, peer support specialists, CHWs, etc. Many discussion groups voiced appreciation for the expansion of peer supports in Utah. Medicaid currently reimburses for peer supports, and discussion groups expressed a desire for private health insurance to reimburse for peer support services as well. That said, there needs to be more provider education on how best to deploy non-licensed team members to ensure they are operating to the best of their ability (i.e., not being used for non-peer-support functions). [See "Peer Supports" text box for more information.]

- Develop a central coordination system with up-to-date navigation supports. Many provider network lists are currently hidden, misleading, do not include provider specialties, and do not indicate whether providers are accepting new patients. This information is important

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Peer Supports

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

Suggested improvements to the peer support model include:
- Better reimbursement (from Medicaid and private health insurance), more funding, and a sufficient wage.
- Establish a peer-support association.
- Create training opportunities that are provided by or with providers who use peer supports.
- Improve the certification process and standardize training to help reduce quality differences. Certification training should be peer led.

for providers who are making referrals and helping with care transitions, patients trying to determine what type of provider they need, as well as employers who are involved in helping their employees manage their behavioral health care needs. This information should be available in EDs, receiving centers, and other crisis access points.

- Improve data sharing. While behavioral health rules and regulations related to confidentiality can inhibit data sharing (and make it difficult to share data across sectors that operate under different rules and regulations such as schools), several discussion groups noted that data sharing could and should improve among providers, payers, and other stakeholders and organizations within the state. Specific examples of opportunities related to improving data sharing include:

  – Expand use of the Utah Health Information Network (UHIN). UHIN access could be extended to behavioral health providers (an example state moving in this direction is Ohio). UHIN could also switch to an "opt out" system rather than an "opt in" system.

  – Support Utah's Child Health Advanced Records Management (CHARM) program and continued development of non-identified reports via Utah's Early Childhood Integrated Data System (ECIDS).

  – Create and utilize bed registries and other digital tools that help provide transparency, accountability, and better manage limited resources. For example, a statewide bed registry could show what beds are available at inpatient, residential, partial hospitalization, med-detox, social detox, receiving/access centers, respite, intensive outpatient, and other high-acuity level-of-care settings.

  – Establish a database or registry system that helps people accessing crisis services identify available services and be referred to appropriate systems or levels of care (for example, monitoring people moving from hospitalization to treatment to ensure appropriate follow up).

  – Develop an asset map that identifies which providers have bandwidth to take on more clients, as well as potential gaps.

  – Develop a data system to monitor patients moving through the continuum of care (and identify real-time gaps).

BEHAVIORAL HEALTH WORKFORCE

While not formally part of Utah's continuum of behavioral health services and supports (Figure 1), Utah's ongoing, and growing, behavioral health workforce shortages are disrupting care across the continuum. Nearly all discussion groups mentioned it as a key challenge in the state. [See "Future Demand for Providers" text box for more information.]

> ### Future Demand for Providers
>
> To maintain the current 100,000 population to provider ratio over the next 10 years, it is estimated that the overall mental health workforce must increase by an average of 125.3 FTEs per year.[126] This does not include SUD providers.

Gaps, Challenges, and Needs:

- *Behavioral health providers across the care continuum.* Specific examples mentioned in different discussion groups include:

  – Licensed clinical therapists
  – Residential providers
  – Psychiatric care
  – Child and adolescent providers
  – SUD providers and prescribers
  – Providers on the west side of Utah's Wasatch Front
  – Providers that serve undocumented populations
  – Providers that serve BIPOC communities
  – Domestic violence counselors
  – Providers that treat individuals with co-occurring mental health and ASDs
  – Providers trained in eating disorders
  – Providers engaged in collaborative care
  – Crisis providers (critical to 988)

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

## Geographic Behavioral Health "Hot Spots"

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

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

Findings from the analysis show (Figure 21):

• South Salt Lake ranks in the top five Utah Small Areas on all four mental health indicators.

• Salt Lake City (Downtown) ranks in the top five on three indicators.

• Magna ranks in the top 10 for three indicators.

• Ogden (Downtown), Kearns, Midvale, Murray, and Taylorsville east/ Murray west each rank in the top 10 for two indicators.

Figure 21: Utah's Behavioral Health Hot Spots, 2020-2022 combined
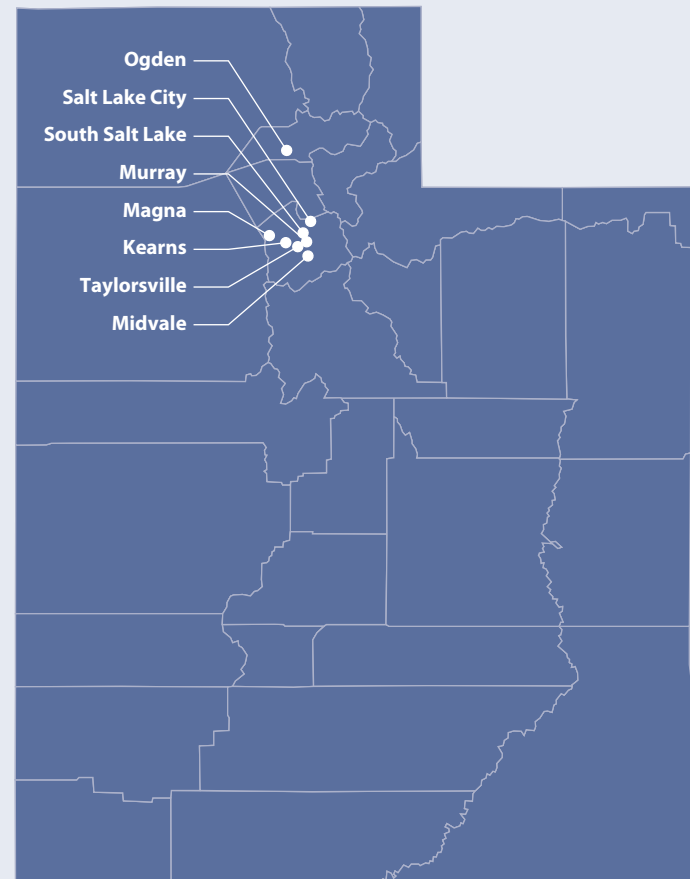
Note: Utah Small Areas that consistently rank high across select mental health indicators. Source: Utah Department of Health and Human Services

Bright Spots:

• *Increased use of telehealth.* Increased use of telehealth, telemedicine, and telepsychiatry is a positive from the COVID-19 pandemic. The Utah Legislature supported this increased use through S.B. 161 (2021), which requires coverage for mental health and SUD telehealth services. (Note: Utah's employer-sponsored self-funded health insurance plans are not impacted by this policy.)[127] Medicare also increased the number of services that could be delivered through telehealth during the COVID-19 PHE and is starting to make some of these changes permanent. [See "Telehealth" text box for more information.]

Telehealth

The proportion of Utah's mental health providers that utilize telehealth services increased dramatically between 2016 and 2021, increasing from 7% to 60% (of survey respondents).[128]

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

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

Suggested Ideas for Next Steps:

- Support the creation of a Masters in Addiction Counseling degree.

- Explore expanding or supporting current pathways to addiction counseling.

- Support tuition reimbursement programs and provide student debt-reduction incentives.

- Develop more training and apprenticeship opportunities, including opportunities for students who received engagement and assessment training.

- Create pathways for upward mobility. Develop bridge and/or tuition support programs to allow non-licensed workers to train and obtain their license to advance into the clinical system.

- Continue to support growth in university-level behavioral health programs. Using appropriations allocated in the June 2020 special session, the University of Utah and Utah State University expanded their Master of Social Work programs by 70 student slots to increase the number of LCSWs in Utah.

- Ensure professionals work to the top of their certification or clinical licenses to better cultivate a workforce with a diverse number of degrees. Ensure professionals and paraprofessionals' skills are not underutilized (paraprofessionals driving vans, LCSWs working as academic counselors, peer support specialists cleaning bathrooms, etc.).

- Reduce the burden of required practicum hours, which delay licensure and discourages entrants, especially non-traditional candidates

- Continue to implement USAAV+ behavioral health workforce recommendations.

- Develop a clear understanding of different classifications of providers and practice scopes, including doctors and nurse practitioners (i.e., prescribers), psychiatric nurses (i.e., prescribe and utilize an integrated care approach), mental health therapists, psychologists, family therapists, clinical social workers, clinical mental health counselors, licensed SUD counselors, peer supports, and case workers, among others. Identify how to maximize available staff. Broaden definitions of care provision (higher levels of education may not always be necessary). Educate legislators about different classifications and scopes as they weigh in on licensing issues.

- Develop a long-term strategic plan for enhancing the recruitment pipeline by: (1) encouraging people at a younger age to consider behavioral health (e.g., start educating sophomores in high school about the field); and (2) employing mentors that guide students to obtain grants and seek loan repayment related to behavioral health fields.

- Increase the compositional diversity of the workforce by: (1) assisting candidates with licensing exams, "something we see is that therapists who are non-native speakers usually fail the test 3–4 times;" (2) offering licensing exams in languages other than English; and (3) developing more inclusive testing methods.

- Expand professionals' scope of practice. For example, expand the ability of psychologists to prescribe certain medicines used in the treatment of mental illness. Note: psychologists can prescribe in a few states such as Louisiana, New Mexico, Illinois, Iowa, and Idaho. In these states, psychologists are required to receive proper training and are only permitted to prescribe certain medicines used in the treatment of mental illness.

- Improve salaries (increase public sector pay to be more comparable to private sector pay) and seek ways to reduce burnout.

- Expand the delivery of behavioral health services in primary care, such as MAT, interventions for mild-to-moderate mental health needs, and maintenance medications for individuals who are stable and no longer in need of specialty of intensive services.

- Use peers and community health workers to support engagement and ongoing recovery.

Appendix: Acronyms & Definitions

ACE	Adverse Childhood Experience
ACO	Accountable Care Organization. Utah Medicaid contracts with ACOs, or health plans, to provide medical services to Medicaid members. Members living in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties must choose an ACO. Members that live in any other county have the option to choose an ACO or the Fee for Service Network. Each ACO is responsible to provide enrolled Medicaid members with all medical services covered by Medicaid. Members enrolled in an ACO must receive all services through a provider on that ACO's network. The provider is paid by the ACO.[129]
AMI	Any mental illness. SAMHSA defines any mental illness as individuals having any mental, behavior, or emotional disorder in the past year that met DSM-IV criteria (excluding developmental and substance use disorders).
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
CHW	Community Health Worker
EAP	Employee Assistance Program. The U.S. Office of Personnel Management defines an EAP as "a voluntary, confidential program that helps employees (including management) work through various life challenges that may adversely affect job performance, health, and personal well-being to optimize an organization's success. EAP services include assessments, counseling, and referrals for additional services to employees with personal and/or work-related concerns, such as stress, financial issues, legal issues, family problems, office conflicts, and alcohol and substance use disorders."[130]
EPSDT	Early and Periodic Screening, Diagnostic and Treatment. The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.
HDHP	High-Deductible Health Plan
HPSA Area Definitions	Health Care Professional Shortage Areas. Mental health shortages are determined across three different domains. (1) Geographic, meaning there is a shortage of providers for the entire population within a defined geographic area. (2) Geographic High Needs, meaning at least 20% of the population has income below 100% FPL, there is a high ratio of children or elderly in the population, there is a high prevalence of alcoholism, or there is a high degree of substance use disorders. (3) Population groups, meaning there is a shortage of providers for specific population groups within a defined geographic area (e.g., low-income individuals).[131] While mental health HPSA designations can include core mental health providers in addition to psychiatrists, most mental health HPSA designations are currently based on psychiatrists only. HPSA designations based on psychiatrists only do not consider the availability of additional mental health providers in the area, such as clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.
HSA	Health Savings Account
ID/DD	Intellectual or Developmental Disabilities
JRI	Justice Reinvestment Initiative
IMD	Institutions for Mental Disease
LCSW	Licensed Clinical Social Workers
Local Authorities	Utah's local authorities oversee the provision of mental health and SUD services to residents in their county. They are responsible for "providing mental health services to persons within the county; and cooperating with efforts of SUMH to promote integrated programs that address an individual's SUD, mental health, and physical health care needs."[132] In many areas they are recognized as the experts in providing behavioral health services to SMI/SED/SUD populations.
MAT	Medication Assisted Treatment
MCOT	Mobile Crisis Outreach Team
MOUD	Medication for Opioid Use Disorder
PEHP	Public Employee Health Program
PMHP	Prepaid Mental Health Plan. Most local mental health authorities (LMHAs) contract with Prepaid Mental Health Plans (PMHPs) to administer and provide mental health services. Medicaid pays PMHPs a capitated monthly fee for each Medicaid member enrolled in their plan. LMHAs may also contract with PMHPs to provide non-Medicaid covered mental health services.
Same Day Billing	Reimbursement rules that prevent providers from being reimbursed for physical and behavioral health services provided on the same day.
SBIRT	Screening, Brief Intervention and Referral to Treatment
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbances. For people under the age of 18, SAMHSA uses the term "Serious Emotional Disturbance" to refer to a diagnosable mental, behavioral, or emotional disorder, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.
SMI	Serious mental illness. SAMHSA defines serious mental illness as someone over 18 having a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.
SUD	Substance Use Disorder. SAMHSA defines substance use disorders as individuals with alcohol or illicit drug dependence or abuse.
TAM	Targeted Adult Medicaid. Utah's Targeted Adult Medicaid Program provides Medicaid services to a capped number of adults without dependent children who are: (1) are chronically unhoused; (2) involved in the criminal legal system through probation, parole, or court ordered treatment needing substance abuse or mental health treatment; (3) needing substance abuse treatment or mental health treatment.
UMIC	Utah Medicaid Integrated Care program. This program integrates physical and behavioral benefits through integrated ACOs in five counties. Adult Expansion Medicaid members in Davis, Salt Lake, Utah, Washington, and Weber counties are required to enroll in a UMIC plan.

Endnotes

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