Utah Department of
Health & Human Services
Integrated Healthcare

Office of Substance Use and Mental Health (OSUMH) Directives

Fiscal Year 2023

April 2022

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A. GOVERNANCE AND OVERSIGHT

i. OSUMH will use the following definitions in the monitoring process:

a. **Compliance:** OSUMH reviewed and verified that the LA or its designees' performance is sufficient and that it meets the requirements of service delivery and provisions within the contract.

b. **Corrective Action:** requires 1) a written formal **Action Plan** to be developed, signed, and dated by the LA or its designee; 2) acceptance by OSUMH evidenced by the dated signature of the OSUMH Director or designee; 3) follow-up and verification actions by OSUMH; and 4) a formal written notification of a return to compliance by the LA or its designee. This notification must be provided to the Bureau of Contract Management (BCM), and may be provided to the Office of Inspector General (OIG).

c. **Action Plan**: A written plan sufficient to resolve a non-compliance issue identified by OSUMH staff. The development of the plan is the primary responsibility of the LA or its designee. Each corrective action plan must be approved by OSUMH staff and should include a date by which the LA will return to compliance. This completion date and the steps by which the corrective action plan will return the LA to contract compliance must be specific and measurable. Each action plan must also include the person(s) responsible to ensure its completion.

d. **Recommendation:** The LA or its designee is in compliance. The LA is encouraged to implement the suggestion, however implementation is not required.

e. Each performance inadequacy will be classified according to one of the following classification levels:

1. **Major Non-Compliance**: Major non-compliance is an issue that affects the imminent health, safety, or well-being of individuals and requires immediate resolution. Non-compliance at this level requires **Corrective Action** sufficient to return the issue to compliance within 24 hours or less. The DHS/OSUMH's response to a major non-compliance issue may include the removal of clients from the current setting into other placements and/or contract termination.
2. **Significant Non-Compliance**: Significant non-compliance is: 1) non-compliance with contract requirements that do not pose an imminent danger to clients but result in inadequate treatment and/or care that jeopardizes the long-term well-being of individual clients; or, 2) non-compliance in training or required paperwork/documentation that is so severe or pervasive as to jeopardize continued funding to the Department and to the LA or its designee. Non-compliance at this level

requires that **Corrective Action** be initiated within 10 days and compliance achieved within 30 days.

3. **Minor Non-Compliance**: Minor non-compliance is a non-compliance issue in contract requirements that is relatively insignificant in nature and does not impact client well-being or jeopardize Department or LA funding. This level of non-compliance requires **Corrective Action** be initiated within 15 days and compliance achieved within 60 days.
4. **Deficiency:** The LA or its designee is not in full contract compliance. The deficiency discovered is not severe enough nor is it pervasive enough in scope to require a formal action plan. OSUMH will identify the deficiency to the LA or its designee and require the appropriate actions necessary to resolve the problem by a negotiated date. This informal plan and negotiated resolution date must be included as a narrative in the monitoring report response. OSUMH will follow-up to determine if the problem has been resolved and will notify the LA or its designee that the resolution has been achieved by the negotiated date. If the LA or its designee fails to resolve the identified deficiency by the negotiated date, formal **Corrective Action** will be required.

ii. **Monitoring/Audit:** Each local authority will be monitored/audited annually. 62A-15-103.(2).(f) OSUMH will review:

a. **Expenses**

1. **Indirect/Administrative Costs**: These costs have been equitably allocated across the organization. See Appendix VII to Part 200 - States and Local Government and Indian Tribe Indirect Cost Proposals or Appendix IV to Part 200 - Indirect (F&A) Costs Identification and Assignment, and Rate Determination for Nonprofit Organizations. **More than one indirect cost allocation plan is not allowed for the same organization. Documentation must be provided showing the equitable application of cost to all payers in the organization. Providing the <u>Medicaid Cost Report</u> satisfies this requirement.**
2. **Allowable Costs:** All expenditures must adhere to Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Each funding source to the division has unique characteristics. The Allocation Letters to the LA outline both the Service Code and Funding Source. Service Code restrictions/requirements can be found in the Finance Formula Handout and the Funding Source restrictions for federal funds can be found in the hyperlinks included in the Allocation Letters that will direct you to the award letter and federal announcements/requirements.
To monitor compliance, each LA will upload a spreadsheet outlining by service code a) the unit of service provided, b) a unique identifier of the client receiving the service, and c) the cost per unit of service. This "cost of unit of service" must be fully burdened with the indirect/administrative costs discussed above. The total costs for services provided must be equal to or greater than what has been charged to OSUMH. OSUMH will select sample entries from the information

provided and will test for adherence to service code and funding source requirements. LA must provide the supporting documentation or provide a way to do this remotely with OSUMH personnel, where the Electronic Health Record (EHR) can be viewed together to verify compliance.
For areas where OSUMH is paying for general services outside of CPT Codes used with Medicaid, the LA will use consistent methodologies to distribute indirect/administrative costs.

3. The Local Authority will send billings on a timely **30-day cycle.**
4. **Findings** from the previous year will be followed-up based upon the timelines provided by the LA in the prior year audit and tracked for resolution for the next year(s) audit.
5. **Subcontractor/Subrecipient Audits:** OSUMH will select subcontractor/subrecipient documents for review based on the OSUMH risk analysis of the LA. Audits will monitor 2-3 organizations for low-risk LA's and 3-6 organizations for moderate risk organizations contracted with the LA. (Current Contract Article 1.2, 1.13, and 1.16)
6. Mental Health or SAPT Block Grants will be audited with the annual financial audit for the LA. **The audit shall also review Cost Allowability, Executive Compensation and Accounting Policies and Procedures.**
7. **Employee Audit to American Rescue Plan Act (ARPA) requirements.**
https://www.federalregister.gov/documents/2021/05/17/2021-10283/coronavirus-state-and-local-fiscal-recovery-funds

b. **LA Contracting Services**

1. **Federal statute:** LA must understand, document and follow Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Please note particularly your responsibilities to determine if those you contract with are subrecipients and what monitoring may be required.
2. **Pass Along Requirements**: Review the LA contract requirements including conflict of interest and liability insurance.

c. **Documentation Review**

1. **Electronic/Remote Review:** The LA will submit documents for OSUMH review through the state owned Google Drive system established with the local authorities for that purpose. LA will make staff available via video conference (ex. Google Meet, Zoom, etc) to review files, documents or materials. All documents must be uploaded to the drive no later than three weeks prior to the scheduled monitoring visit.
2. **EHR Access:** The LA will provide temporary EHR access and training to OSUMH monitoring/audit personnel for the purpose of chart reviews and, if necessary, verification that clients meet funding requirements.

iii. **Other:**

a. Cannabis: LAs, sub-recipients and contracted providers must comply with the following: SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 C.F.R. 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana).

b. **Insurance**: Substance Abuse Block Grant and Mental Health Block Grant funds may be used to provide cost-sharing assistance for behavioral health insurance deductibles, coinsurance, and copayments to assist eligible clients receiving service at an eligible provider. Block grants may also be used to help individuals meet their cost-sharing responsibilities under a health insurance or benefits program, including high risk pools. For the Guidelines, follow this link.:

c. **Health Disparity**: Each LA will identify an individual, staff member/position responsible to collaborate with OSUMH to develop and implement an "Eliminating Health Disparity Strategic Plan " with long and short term goals and action steps.

iv. **The LA will ensure** that subrecipients, subcontractors and providers have current licenses, certifications, insurance, BCI checks, code of conduct, harassment training, annual dual employment & conflict of interest forms and verified I9's. (Utah Code 17-43 Part 2-201 4(a)(b) - 5(f)(i)) Using one of the following methods: keeping physical/electronic copies, through the Medicaid credentialing process, annual monitoring; another monitoring report in the past year that has verified these items.

v. Required Audit Timelines are as follows:

a. **Four weeks** prior to the audit opening meetings the initial letter and documentation will be sent out to the LA's

b. **Three weeks** prior to the audit all clinical documentation/access will be uploaded/granted for the audit.

c. **Two weeks** prior to the audit, **all documentation** including G&O, Service Spreadsheets, Prevention, Peer Support and Clinical will be uploaded to the Google Drive.

B. PREVENTION SERVICES

i. **Substance Use Disorder Prevention:** The LA must use a Community Centered Evidence Based Prevention (CCEBP) system such as Communities that Care (CTC), PROSPER, or CADCA Coalition Academy

a. All prevention personnel including contracted staff must certify in the Utah Substance Abuse Prevention Specialist Training (SAPST) and recertify at least every 3 years. LA prevention coordinators may choose the Universal Prevention Curriculum (UPC) Foundations or Community course as an alternative.

b. Complete a OSUMH approved Logic Model that identifies all OSUMH funding sources for all substance use disorder prevention programs and strategies.

c. Submit an annual Logic Model Review by November 15th of each year that summarizes performance of prevention programs, policies and strategies based on the short and long term outcomes identified in the approved logic models.

d. Each LA must spend a minimum of 30% of SAPT Block Grant funds on prevention policies, programs, strategies, and administration.

e. Use the NIDA Research Guide for Preventing Drug Use Among Children and Adolescents (Redbook) as a guide to implement the SPF: http://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf.

f. Increase the number of evidence-based, as defined by the OSUMH Evidence Based Workgroup, policies, programs and strategies to a standard of 90%. The remaining 10% of prevention policies, programs and strategies are to be research informed with a plan to be submitted to the Evidence Based Workgroup (EBW) within one year.

g. LA's in receipt of CTC grant funds must:

1. Hire a CTC Coordinator and implement the CTC process.
2. The CTC coordinator will work closely with the LA prevention coordinator to ensure CTC is implemented with fidelity.
3. The CTC/FPL funding must be matched by both dollars and in-kind contributions by county, city or community partners.
4. Funds are primarily to be used for the CTC Coordinator position but the LA may use a portion of these funds, with permission from the DHS/OSUMH program manager, to fund additional prevention activities as described in the CTC model as found at www.communitiesthatcare.net.
5. Ensure CTC training and technical assistance to the CTC coordinator within 60 days of coordinator hire date and proceeding as outlined in the CTC planning model found at www.communitiesthatcare.net .
6. Monitor the CTC Coordinator's performance to ensure program fidelity.
7. Use the OSUMH approved CTC report template to provide annual progress reports by December 31 of each year to the DHS/OSUMH that include progress reports on the phases of CTC implementation.
8. The CTC Coordinator must be certified in the Substance Abuse Prevention Specialist Training and CTC coordinator training within one year of the

coordinator's start date. The LA must email a copy of the completion certificates to the DHS/OSUMH program manager within one month of the completion date.

C. SUICIDE PREVENTION

i. **Suicide Prevention:** LAs must identify and define current strategies and programs implemented for suicide prevention, intervention, and postvention. Strategies and programs should be evidence-based strategies and align with the Utah Suicide Prevention Plan.
https://drive.google.com/file/d/1V4cgYvf_JGs1CNvBYY2XmoFfwSPQIPM3/view

a. LAs should have at least one staff member with suicide prevention responsibilities trained in the following OSUMH's Suicide Prevention programs:

1. Suicide Prevention 101 training
2. Safe and Effective Messaging for Suicide Prevention
3. Suicide Prevention Gatekeeper training, such as Question-Persuade-Refer (QPR), Mental Health First Aid (MHFA), Talk Saves Lives, or Applied Suicide Intervention Skills Training (ASIST).

b. LAs must coordinate with Local Health Departments and local school districts to develop a plan that identifies roles and responsibilities for a community postvention plan aligned with the state Community Postvention Toolkit. Identify existing partners and intended partners for postvention planning.

c. LAs participating in the Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant Program will implement skill-based programming, gatekeeper training, community or school based screening activities, and crisis follow up services after inpatient or emergency department visits. Include an annual report.

d. As participating in the Comprehensive Suicide Prevention grants will implement primary prevention programs, suicide intervention supports including gatekeeper training, and community postvention planning. Project deliverables include:

1. **By year 2**, a written comprehensive suicide prevention plan aligned with the Utah Suicide Prevention State Plan. Funding recipients must also submit a written postvention response plan and communication protocol for their organization.
2. **By year 3** funding recipients must submit a written community postvention response plan. Complete Instructor Training for the following:

a. Safe and Effective Messaging for Suicide Prevention
b. Suicide Prevention Gatekeeper training, such as

Question-Persuade-Refer (QPR), Mental Health First Aid (MHFA), Talk Saves Lives, or Applied Suicide Intervention Skills Training (ASIST).

e LAs receiving mini grant funding for the Live On Utah statewide suicide prevention campaign must submit an implementation and sustainability plan for the implementation of culturally appropriate suicide prevention messaging in their area. Provide a summary of implementation in the community.

D: CRISIS AND EARLY INTERVENTION

i. LAs shall develop services, activities and strategies designed to intervene with individuals who are **misusing alcohol and other drugs**. Strategies include:

a. Implement evidenced-based indicated prevention strategies designed to intervene with youth and adults who are misusing alcohol and other drugs.

b. Work with community partners to implement brief motivational interventions and/or supportive monitoring in healthcare, schools and other settings.

c. Provide acute stabilization and withdrawal management to assist individuals' withdrawal from a psychoactive substance in a safe and effective manner.

d. Overdose prevention:
   1. Educate staff to identify overdose and to administer Naloxone;
   2. Maintain Naloxone in facilities; and
   3. Provide Naloxone kits, education and training to individuals with opioid use disorders (OUD) and when possible to their families, friends, and significant others, and persons receiving crisis services whenever possible

ii. LAs that engage in **community oriented crisis services** should use SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit as guidance for development, implementation, and quality improvement efforts.

a. LAs that provide Mental Health Crisis Outreach Teams (MCOT) will provide services as outlined in Rule R523-18. Local mental health authorities must deploy MCOT from the statewide crisis line when requested by the state crisis line without reassessment or re-triage. MCOT teams must deploy to community partners and stakeholders. Deployment priority must be given to law enforcement, EMS, Fire, 911 dispatch and the statewide crisis line. Any requests to be exempted for any requirement outlined in rule must be submitted to the OSUMH Director and if approved be attached as an addendum to the area plan. Area plans should describe all services to be included under "crisis stabilization". Providers must attend scheduled coordination meetings with the Utah Crisis Line and OSUMH staff.

c. LA Receiving Centers will provide services as outlined in Utah Code § 62A-15-118 and Rule R523-21. LAs must coordinate with local law enforcement, EMS, 911, and emergency departments, detoxification facilities, and other community stakeholders. Providers must submit data as outlined in the FY2023 Crisis and Stabilization Specifications.

d. Stabilization and Mobile Response (SMR) services must be delivered consistent with the SMR policy and procedures manual. Provider must provide verification of services and authorizations prior to submission of invoices to DHS for payment. This includes the number of people served, and the types of services received.

iii. Providers receiving monies for MCOT, Youth MCOT, Receiving Centers shall be responsible for ensuring that their programs are leveraging Medicaid monies whenever possible. Programs unable to bill 30% of their services to Medicaid for any crisis service code will be subject to 20% repayment.

Within the Northern Region, to include youth MCOT and SMR programs to be operated by Davis Behavioral Health, Bear River Mental Health, and Weber Human Services, Intensive Stabilization services shall continue to be offered in accordance with the SMR policy and procedure manual. Mobile deployment and related crisis programming shall be supported with youth mobile crisis outreach services. Davis Behavioral Health, Bear River Mental Health, and Weber Human Services shall submit data independently through OSUMH as outlined in the FY2023 Crisis and Stabilization Specifications. These areas shall develop a plan with the OSUMH for exceptions to Crisis and Stabilization Specifications submissions and authorizations as required through the above outline policy and procedures manual. Authorizations in the Northern Region will be managed independently, but a committee of partners shall be formed and maintained for review, collaboration, and program alignment of stabilization. Program representation and collaboration should also be offered by these areas for ongoing state level programmatic operations planning to address the mission of SMR and regionalization in programming in a collaborative way to meet the needs of children, youth and families. OSUMH shall assume onboarding of new staff in these regions, as well as offer technical assistance and monitoring of the program.

E. MENTAL HEALTH SERVICES

i. LAs must use the **"unfunded"** State General Funds dedicated to children, youth and adults to serve unfunded clients. These funds are subject to the County 20% match requirement and may not be used for: Medicaid match, or for services provided to a Medicaid client or for services not paid by Medicaid, for a Medicaid client, or for emergency or inpatient services.

ii. Data from the **Outcome Questionnaire (OQ) or Youth Outcome Questionnaire (YOQ)** must be shared with the client and incorporated into the clinical process, as evidenced in the chart (excluding children age five and under).

iii. LAs shall continue to establish, maintain, and/or expand access to **Adult, Youth, and Family Peer Support Services**. LA should develop policies, procedures, and guidelines to support Certified Peer Support Specialists (CPSS) and Family Peer Support Specialists (FPSS) which include the following:

a. CPSS and FPSS team internally with other staff members within the organization to get referrals, connect to resources, and staff individuals/families/youth they are serving.

b. CPSS, FPSS and supervisors receive ongoing training and supervision specific to the LA and local area needs.

c. CPSS and FPSS supervisors have reviewed the state peer supervisor manual, "Utah Peer Support Supervisor Guide".

d. Peer support specialists, or a representative peer for the peer support program, shall meet with LA leadership at minimum semi-annually to discuss peer involvement in the agency.

iv. LAs shall have a policy for **screening for and responding to suicide risk.** Records must contain a suicide screener, suicide risk assessment, and a suicide/crisis safety plan, when indicated, that includes indication of lethal means counseling when clinically indicated.

v. High Need Client Care Plan:

a. Each Local Authority will provide a plan to address appropriate service provision for clients with complex behavioral health conditions who require frequent engagement, and who are clinically indicated to need multiple mental health supports to remain in the community. Plan must include a strategy to do outreach and tracking for patients under commitment and Assisted Outpatient Treatment (AOT) court orders.

vi. LAs must participate in **Utah State Hospital (USH) Adult and Children Continuity of Care** meetings in accordance with Rule R523-2-12.

a. Adult Outplacement funds should be used to provide creative interventions, non-covered Medicaid services, wrap-around supports, housing and recovery enhancement for the patient and must be documented within the plan of care. Outplacement expenditures specific to individual patients must be tracked internally. Eligibility includes patients who are currently receiving inpatient care at USH when current available resources to discharge from USH are inadequate to meet the individual's needs, or patients who are targeted for diversion (diversion is defined as preventing or diverting from USH inpatient admission). Patients referred for discharge must be discharged from USH within 30 calendar days, with consistent documentation in the USH electronic system.

b. Written or electronic requests for Children's Outplacement Funds are submitted to OSUMH by the LMHA representative for each individual client. Requests are then reviewed during the Children's Continuity of Care meeting. Funding is awarded by committee vote with OSUMH approval. The ultimate decision regarding the use of Outplacement Funds rests with the Assistant Director.

vii. **First Episode Psychosis (FEP)** Mental Health Block Grant (MHBG) funds should be used to treat individuals with early serious mental illness" and not for primary prevention must:

a. Not use funds to supplant current funding of existing activities.

b. Maintain client records, training records, and submit semi-annual reports that follow a template provided by DHHS/OSUMH.

c. Follow the Prevention and Recovery of Early Psychosis (PREP) Practice Guidelines. OSUMH will provide a copy of the Practice Guidelines to FEP program staff at LAs.

d. Participate in OSUMH evaluation efforts to assess the effectiveness and outcomes of the early psychosis program. This includes the annual fidelity review on the PREP Practice Guidelines.

viii. **Integrated Care Strategies:**

a. Each LA will implement integrated programming that addresses an individual's substance use, mental health, and physical health.
   1. Each LA will use assessments, assessment updates, and appropriate screening tools to identify the aforementioned needs.
   2. Each LA will have at least one training annually to train providers in appropriate and coordinated referrals with follow-up to meet the identified health needs of the clients.

b. Local Authorities will collect information on clients' physical health and primary care provider status during intake, and will update this information during care transitions, to facilitate client connection to needed healthcare services.

c. Local Authorities awarded funding through SB041 will:

   1. Implement an Integrated Behavioral Health Care Services program through the addition of staff, training of staff, service provision, and necessary software support as described below.
   2. Within three months of the allocation award date, hire or formalize contractual relationships with the necessary staff in order to provide physical and behavioral health services.

3. Training provided to staff must include training on integrated behavioral health care, and valid physical health screening assessments. See section V.B.1.a.-d. for examples of relevant assessments.
4. Provide the integrated care services:
    a. Patient identification and diagnosis. Screen for and diagnose behavioral and physical health problems using valid tools to assess and document baseline symptom severity;
    b. Engagement in the integrated care program. Introduce the care team and enter the patient into the electronic health record;
    c. Provide evidence-based treatment:
        (1) Develop and regularly update the person-centered treatment plan to include behavioral and physical health components;
        (2) Provide evidence-based health care treatment; and
        (3) Prescribe and manage medications as clinically indicated.
    d. Systematic follow-up:
        (1) Use the Contractor's patient registry to monitor patient contacts, treatment response, and treatment side effects;
        (2) Identify target patients who are identified as not improving by the behavioral and physical health clinical team for psychiatric consultation and treatment adjustment; and
        (3) Create and support relapse prevention plans when patients behavioral and physical health are determined as substantially improved by the clinical team.
    e. Communication and care management:
        (1) Coordinate communication between providers after a patient visit that facilitates the necessary patient treatment; and
        (2) Track referrals to specialty care, social services, and community-based resources.
    f. Oversight and quality improvement:
        (1) Provide administrative and clinical support and supervision for the program; and
        (2) Routinely examine provider and program level outcomes and use this information for quality improvement.
5. Contractor may use funds from this contract to purchase or upgrade software necessary to support or implement a program. If other resources are necessary to support or implement the program, they must be pre-approved in writing by the Department of Health and Human Services, Office of Substance Use and Mental Health ("DHHS") program staff managing this project.

6. Outcome Measures:
    a. Outcomes:
        (1) Improved patient physical health outcomes. This must include at least the following indicators:

            i. Body mass index;
            ii. Waist circumference;
            iii. Blood pressure;
            iv. Hemoglobin A1C;
    b. Increased patient access to integrated care programming by hiring and contracting for behavioral or physical health professionals and case managers to provide integrated care services;
    c. Increased provider understanding of integrated care practices; and
    d. Cost analysis of the capability of Medicaid to support integrated care programming beyond the funding period.

7. Measures:
    a. Patient outcomes will be tracked through the Contractor's Electronic Health Record ("EHR"). Each patient receiving services from this funding will be entered into the EHR so their outcomes can be tracked over the course of the program.
    b. Number of staff hired or employed, and contracts completed with behavioral and physical health professionals and case managers to provide integrated care services. The Contractor shall meet with DHHS staff within 30 days of the effective date to determine staffing needs and how many will be hired;
    c. 100% of staff funded by this program shall receive integrated care training before this funding ends; and
    d. Cost analysis will include the total costs associated with each visit for each patient receiving integrated care services. This analysis will be included with the quarterly reports.

8. Reporting: Reports shall be submitted to DHHS program staff within 30 days after the end of each quarter, on January 31, April 30, July 31, and October 31 of each year of the contract. The reports will include the following information:
    a. Number of patients seen;
    b. Number of behavioral health contacts;
    c. Number of physical health contacts;
    d. Number of patient contacts with emergency services to include:
        i. Emergency department;
        ii. Inpatient hospitalization;
        iii. Ambulance;
        iv. Jail stays.
    e. Aggregate data from the EHR to show:
        i. Number of screens for physical and behavioral health

assessed;

ii. Scores from each assessment to track treatment outcomes over time;

f. Number of staff hired and position title, if applicable;
g. Number of contracts, Memoranda of Understanding, or Business Associate Agreements completed and purpose of contract, if applicable;
h. Number and type of trainings provided;
i. Number and type of trainings attended; and
j. Total costs associated with each visit for each patient receiving integrated care services.

ix. **Additional Quality Improvement Strategies:**

a. Maternal and early childhood mental health

1. Each LA will identify at least one provider that is a specialist in maternal mental health, or will identify a provider to be trained as a specialist in maternal mental health. Specialists will have received 12 hours of maternal mental health training and will be available for in-person and telehealth services. LAs will provide the name and stage of training for each identified maternal mental health specialist annually.
2. Each LA will identify at least one staff member or team to be trained in infant and early childhood mental health to provide evidenced-based practices and modalities for children birth to five. LAs, when appropriate, should also refer and collaborate with other early childhood community partners to ensure coordinated treatment and increase support for young children and their families.

b. Youth in Transition: Each LA will identify a liaison to work with OSUMH to develop a process to receive meaningful input from transition-age youth (age 16-25) for a program that serves transition-age youth. An OSUMH staff will provide regular communication and technical assistance.

x. **Mental Health Early Intervention (MHEI)** Funding is reserved for children and youth who may or may not have a Serious Emotional Disturbance (SED) designation, but are at risk to become so without early intervention services. Service provision should focus on Family Peer Support services, Mobile Crisis Teams, and School-Based Behavioral Health. If funds are received through Local Education Agency (LEA) contracting, report the new funding in Form A2 and Form A. This legislative funding requires the tracking of spending and outcomes related to each service provision, per legislative intent language and requires quarterly completion of the MHEI Quarterly Data and Annual Outcomes Report via the Qualtrics survey: https://utahgov.co1.qualtrics.com/jfe/form/SV_43nStXZzUBHtekt. Funds will be allocated on a formula and are subject to the County 20% match requirement.

xi. **Operation Rio Grande:** (CITE) Salt Lake County must provide or contract to improve behavioral health, housing coordination and access to public health benefits for homeless and chronically homeless veterans and other homeless individuals with behavioral health disorders. The LA Funds must provide treatment, case management and Recovery Support Services based on need using the Assertive Community Outreach Treatment (ACOT)/Assertive Community Treatment (ACT) model, to include Housing First, Trauma-informed care, and motivational interviewing. Ensure the assessments of eligible individuals include, but not be limited to, the Service Prioritization and Decision Assistance Tool (SPDAT).

xii. **Southwest Behavioral Health Center** (SBHC), provides short-term mental health services to individuals and families in plural marriage communities without other payor resources in need of mental health services. This funding is not intended to supplant established Medicaid coverage but rather to enhance the service array. Short-term mental health services reduce mental health symptoms and increase wellness, recovery and employment.

a. Funds are used for short-term mental health services and personal safety and healthy relationship classes for current and former members of polygamous communities ineligible for Medicaid.

b. SBHC may utilize subcontractors to provide short-term mental health services.

c. All individuals identified as a current or former member of a polygamous community requesting mental health services will be screened for eligibility for Medicaid and explore all other options for funding including but not limited to private insurance, VOCA, other grants, or private-pay.

d. To qualify for use of these funds, an individual must meet all of the following: Have a diagnosable mental illness or substance use disorder or are participating in treatment with a family member with a diagnosis; Have a history or current participation within a plural marriage community; Have no other resource for funding; Be a resident of Utah, and willing to consent to behavioral health treatment or classes.

xiii. **Projects for Assistance in Transition from Homelessness** (PATH), will provide or contract for services to assist eligible individuals not funded through other programs. PATH funds are to be used as defined in https://uscode.house.gov/view.xhtml?req=(title:42%20section:290cc-22%20edition:prelim) \

a. LAs providing PATH services will use the Homeless Management Information System (HMIS) for tracking PATH data and provide to the DHS/OSUMH PATH Program Director or as otherwise directed the following:

1. PATH budget including a cash match of $1 for every $3 of federal PATH funds is required. No more than 4% of the federal PATH funds received must be used for administrative expenses.

2. PATH Intended Use Plan: Note that the PATH provider must not expend PATH program funds for Medicaid funded services or other federal match purposes, to purchase or to pay for construction of any building or structure, or any of the PATH eligible client's lease expenses beyond the project period.

xiv **Behavioral Health Home** for individuals with substance use and mental health disorders. The LA must:include the Behavioral Health Home as a Cost Center in the Medicaid Cost Report if it is to be included as an expense against the budget for allocation.

xv. **Autism Spectrum Disorders** (ASD) Mental Health Preschool programs will:

a. Serve preschool-aged children with ASD, typically aged two through five, and their families, but exceptions are allowed with approval from OSUMH.

b. Provide services for children that include assessment of ASD and related mental health concerns, therapeutic interventions to address ASD needs, and referral to other resources.

c. Parents/guardians and siblings of children with ASD should receive psychoeducation, guidance, and counseling.

d. Use funding for non-Medicaid services.

e. Maintain a minimum constant enrollment of at least 20 children and a list of other eligible children not yet enrolled in kindergarten.

f. Use evidence-based curriculum to provide therapeutic and educational services for individuals with autism.

g. LAs will provide:

1. Data collection, tracking, and monitoring to guide treatment planning and implementation
2. Auxiliary services include but are not limited to psychiatric services, diagnosis and treatment, medication management, case management, and linking families to other treatment and community resources.
3. Strength-based assessment of each child that includes an evaluation of the child's developmental, cognitive, adaptive, and behavioral functioning;
4. An individualized treatment plan for each child enrolled.
5. Transition planning with the child, parent/guardian and the school district prior to the end of services;
6. Opportunity for parents to participate in the classroom on a weekly basis as their schedule allows;
7. At least six (6) hours of training designed to improve the quality of care for each employee annually.

F. SUBSTANCE USE DISORDER TREATMENT SERVICES

i. The LA must provide **substance use disorder treatment** designed to help individuals stop or reduce harmful substance misuse, improve their health, social function and manage their risk for relapse.

a. Clinical services including assessment, withdrawal management, treatment planning, treatment management, care coordination and continuing care management should be consistent with the most current ASAM Criteria.

b. To receive Women and Children's Residential Treatment funds, LAs must submit a proposal with the area plan that includes:

1. Justification for continued funding
2. Proposed use of the funds
3. Assurance that services meet a statewide need and that individuals from other counties will have access to services outside of original catchment area
4. A comprehensive budget

c. Children with Parents in Residential Treatment funds are to be used for children reuniting in family treatment programs and children living with parents receiving residential substance use disorder treatment. Funds must be used to pay for the following services:

1. Room and board for the child,
2. Therapeutic day care to address developmental needs, reduce potential for substance use disorders, and their issues of sexual and physical abuse and neglect,
3. Case management and transportation for behavioral and physical health care services
4. Ongoing assessment that will include, but not be limited to: developmental adjustment; motor skills; cognitive skills, health, including immunization history; interaction with mother and other adults; language and general affect.
5. Funding is contingent on maintaining concurrent residential therapeutic services for children with the goal of reunification with their parent(s).

d. State Opioid Response (SOR, SSOR) grant funds are for the provision of prevention, treatment and recovery support for individuals with OUD and stimulant use disorders. Allowable uses for SOR/SSOR funding include:

1. Services provided by federally certified OTP to individuals with OUD.
2. Services provided by Office Based Treatment providers to treat OUD using Medication Assisted Treatment (MAT).
3. Provision of evidence based-behavioral therapies for individuals with OUD.
4. Support innovative telehealth in rural and underserved areas to increase the capacity of communities to support OUD prevention, treatment and

recovery services.

5. Implement or expand access to FDA approved medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono product mono product mono product mono product formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine) in combination with psychosocial interventions.
6. Provide treatment transition and coverage for patients who are incarcerated or who are reentering communities from criminal justice settings or other rehabilitative settings.
7. Enhance or support the provision of peer support and other recovery support services designed to improve treatment access and retention and support long-term recovery including relapse and suicide prevention efforts for individuals with OUD.

e. LAs providing treatment, case management and drug testing for drug courts must:

1. Be certified by the Administrative Office of the Courts (in accordance with Utah Code of Judicial Administration Rule 4-409) throughout the contracted period.
2. Ensure drug testing occurs at least two times per week and on weekends and holidays (required by the Utah Code of Judicial Administration, Rule 4-409 and the Judicial Council Monitoring checklist).
3. Serve participants identified by a validated criminogenic risk tool as High Risk/High Need.
4. Document criminogenic risk in each participant's clinical record.
5. Submit Drug Court Service Reports as requested by DHS/OSUMH.
6. Disclose all fees related to drug court (treatment, case management, drug testing, court fees etc.) to individuals prior to their admission.
   (a) All fees must be based on the approved fee policy and schedule.
7. There must not be any prohibitions against MAT or a requirement to be abstinent from medications used in addiction treatment in order to enter drug court, progress or complete drug court.
8. Submit any evaluation or research to the DHS/OSUMH within 90 days of completion of the evaluation and research.
9. Not use funds to pay for law enforcement, tracking or supervision conducted by law enforcement officers.

G. RECOVERY SUPPORT SERVICES

i. **Recovery Support Services** (RSS) are voluntary services designed to help people with mental and substance use disorders manage their conditions successfully.

a. RSS participation may occur prior, during, after, or in lieu of treatment.

b. RSS targets at least one of the four major dimensions that support recovery:

1. Health—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
2. Home—having a stable and safe place to live.
3. Purpose—conducting meaningful daily activities and having the independence, income, and resources to participate in society.
4. Community—having relationships and social networks that provide support, friendship, love, and hope.

c. RSS services must follow the Recovery Support Manual.

ii. **Recovery Residence Housing** provides drug and alcohol free housing to clients who are at risk for relapse as a result of their current housing situation.

a. Recovery Residences must be licensed by the Department of Health and Human Services Division of Licensing as one of the following:

1. A residential support agency as defined in Utah Code § 62A-2-101
2. As a residential treatment agency as defined in 62A-2-101 that is associated with a sober/transitional housing unit
3. A recovery residence as defined in Utah Code § 62A-2-101.

iii. Each LA will establish **supported employment and individual placement and support (IPS) programming:**

a. Employ at least one specialist in supported employment, or identify an employee to be trained as a specialist in supported employment. Specialists must receive 4 hours of employment training per year.

b. Establish a referral process for the Department of Workforce Services/Vocational Rehabilitation.

c. Implement a zero exclusion policy within the agency, supporting individuals who want to become employed.

d. Identify a plan to improve employment-related actions as a function of addressing social determinants of health.

H. SERVICE, SATISFACTION AND OUTCOME DATA

i. **Purpose**: All service, satisfaction and outcome data described in this section shall be submitted to OSUMH by providers according to the guidelines that follow. Data findings may result if data are determined to contain systemic inaccuracies.

ii. **Service data**

a. Service data is required for all clients receiving substance use disorder or collateral treatment (TEDS and SUD event), mental health treatment (MHE), crisis or stabilization services (CS), recovery support services (RSS), or indicated prevention services (IP).

    1. Providers who contract out for services are required to report client service data to the OSUMH for all clients regardless of who is providing the service or where the service is provided.

b. Specifications detailing data file requirements for each treatment or service category (i.e., TEDS, MHE, CS, RSS, and IP) are available for download from the OSUMH website at https://DSAMH.utah.gov/reports/data-specs.

c. Electronic submissions of the service data files (i.e., TEDS, SUD event, MHE, CS, RSS, and IP) must be made through the SAMHIS file utility app. Files must be submitted on or before the last day of every month, for services provided in the previous month.

d. Service data submitted through the file utility to OSUMH will be prepared by the OSUMH data team for submission to the Federal Government. Data will be analyzed and used for the Mental Health Block Grant, for annual reporting on the scorecard, and to assess numbers and types of clients served, numbers and types of services provided, and to assess changes in social determinants of health and other outcomes.

    1. Results that do not meet federal or internal benchmarks may show as red on the scorecards and may result in audit findings.
    2. Data findings may result for substance use disorder providers when non-methadone outpatient or intensive outpatient admissions, opened more than 2 years prior with no services in the fiscal year, account for more than 4% of clients served in the fiscal year, or for any residential or detox admissions open for more than 2 years without service records.

iii. **Consumer satisfaction data:**

a. Each provider is required to submit consumer satisfaction survey results for a minimum of 10% of unduplicated adults and children for whom substance use or mental health service data are submitted, regardless of the modality of treatment or length of stay in treatment.

    1. Providers that submit surveys for less than 10% of clients will receive a finding in the audit report.

b. The consumer satisfaction tools required by OSUMH are:

    1. The Mental Health Statistical Improvement Program (MHSIP) self-report satisfaction survey. This survey is to be administered to adults receiving substance use disorder or mental health treatment.
        a. The 10% denominator for MHSIP includes all adult clients

receiving non-jail-based services in the previous fiscal year.

2. The Youth Satisfaction Survey (YSS). This survey is to be administered to children or youth ages 12-17 (YSS) receiving substance use disorder or mental health treatment or to the parents or caregivers (YSS-F) of children under age 18.
    a. The 10% denominator for YSS includes all clients aged 12 - 17 receiving services in the previous fiscal year.
    b. The 10% denominator for YSS-F includes all clients aged 5 - 14 receiving services in the previous fiscal year.

c. All consumer satisfaction surveys are available in English and Spanish. The surveys are given as a point-in-time convenience survey from January 1st through May 1st of each year. Surveys can be accessed via the OQ Analyst System or through survey links sent to each provider annually. Surveys completed between May 2nd and December 31st will not be used in reporting or analysis.

d. Consumer satisfaction survey results are analyzed by the OSUMH data team and are used for reporting information to the Federal Government, for the Mental Health Block Grant, for annual reporting, to assess client perception of treatment and to improve services to consumers.

    1. Aggregate numbers for the State and specific data for the provider are returned to the provider.
    2. Aggregate numbers for the State and for each provider are publicly posted on a scorecard that includes comparisons from the previous year's results and with national averages, when available.
        a. For adult clients, each agency should meet positive outcomes of at least 75% of the national averages in consumer reported domains.
        b. For children, each agency should meet positive outcomes of at least 75% of the state averages in consumer reported domains.
        c. Providers who receive less than 75% of the established target for the outcome domains may receive a finding in the audit report.

iv. **Mental Health Outcomes data:**

a. OSUMH requires outcome assessments for 75% of unduplicated clients with more than five years of age for whom mental health service data are submitted that experience serious mental illness (SMI) or serious emotional disturbance (SED). Individuals who receive only medication management services, or who are served while in jail are excluded from this requirement. SMI and SED are defined by the Utah scale on serious mental illness including substance use disorders and the Utah scale for children/adolescents with serious emotional disorders.

b. The approved outcome tool for clients receiving Mental Health treatment is the Outcome Questionnaire (OQ).

    1. The OQ versions valid for use with adults include:

a. Q® 45.2 - Adult Outcome measure (completed by clients ages 18+);
b. Q® 30.2 – Adult Outcome measure (completed by clients ages 18+);
c. SOQ® 2.0 - SMI Outcome instruments (completed by clients ages 18+ or their clinician)

2. The OQ versions valid for use with children/youth include:

a. YOQ® 2.01 - Youth Outcome measure (completed by parent or guardian of clients ages 4-17);
b. YOQ® 2.0 SR - Youth Outcome measure (self-report for clients ages 12-18);
c. YOQ® 30.2 - Omni form Youth Outcome measure (administered to parent/guardian or to clients ages 4-17);
d. YOQ® 30.2 PR- Omni form Youth Outcome measure (administered by parent/guarding of clients ages 4-17); and
e. YOQ® 30.2SR-Omni from Youth Outcome Measure (self-report for clients ages 12-18).

c. OQ assessments must be entered into the OQ Analyst Hosted System (OQA-HS).

d. OSUMH will obtain results directly from the OQA-HS and will use results to evaluate program and patient treatment effectiveness. Aggregated results of data analysis and reporting will be shared with LMHAs and used to inform others regarding system effectiveness and clinical best practice. OQ results will be included on the Mental Health scorecards and will include utilization rates, match rates and the percentage of clients with different treatment outcomes.

1. OQ/YOQ utilization is defined by minimum frequency requirements that include administration at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt).

a. Providers with a utilization rate lower than 75% will show as red on the scorecard and may receive a finding in their audit report.

2. Match rates are defined as the percentage of client identifiers associated with OQ scores that match the client identifiers in the Mental Health Event file.

a. At least 90% of OQ clients must match mental health records. Providers with more than 10% of their OQed clients that do not match may receive a finding in their audit report.

i. To prevent this, OSUMH recommends that providers incorporate the client demographic Web Services Interface (WSI) into their Electronic Health Record (EHR) so identifying data items are accurate in the OQ system and match identifying data from MHE

files.

3. To increase clinical effectiveness, OQ/YOQ should be included in and adopted as part of the standard intake and ongoing clinical protocol. Providers are encouraged to administer OQs to individuals who experience serious mental illness or serious emotional disturbance at every encounter for relevant services.

4. The OSUMH requires a policy to be in place that prescribes the appropriate clinical response, follow-through, and patient, family, or guardian involvement for the empirical results of the OQ/YOQ.

v. **Substance use treatment outcomes data:**

a. OSUMH recommends the use of the Substance Use Recovery Evaluator (SURE) tool with clients receiving substance use treatment.

1. OSUMH recommends entering SURE assessments into the OQ Analyst Hosted System (OQA-HS) or MHS Assessments system (GAINS).

2. OSUMH recommends administering the SURE at intake, every thirty days and at discharge/discontinuation.

vi. **Prevention data requirements:**

a. The Information System Data Set for Universal and Selective Prevention is DUGS (Data User Gateway System). The LA must enter prevention data into the OSUMH approved system within 45 calendar days of the delivery of service.

I GRANT AND CONTRACT DATA AND REPORTING REQUIREMENTS

i. Each grant and contract has its own data and reporting requirements. LA's that receive funding through grants and contracts are required to submit accurate data in a timely manner.

a. Most federal substance use and mental health service grants require GPRA measures. GPRA assessments include both service and program data. Service data are typically due at baseline, six months post-baseline and at discharge. These data are typically entered directly into the federal system by the provider. Program data are typically due quarterly and are most often provided to the OSUMH program administrators for entry into the federal system.

ii. LAs that receive funding through grants and contracts are required to complete reporting on or before the report due date.

a. Quarterly reporting on most federal grants is due on or before the last day of April, July, October and January for events and outcomes in the preceding

quarter. Quarterly reporting for the IPS Learning Community is due the last day of March, June, September and December.

b. Reports may be due directly from the LA to the funding agency. These reports must be submitted by the due date.
c. For grants in which DHS/OSUMH inputs the data or submits the report, data or information must be provided to DHS/OSUMH prior to the due date.

iii. LAs will coordinate with OSUMH and the funding agency in all required planning, implementation, data, billing and reporting requirements associated with the grant or contract and will hold any subcontractors to the same specifications.

J. PERFORMANCE METRICS

i. Performance metrics will be available on the annual scorecards, in reports posted to the OSUMH website, through the use of public-facing dashboards and through audit tools. These metrics are aligned with OSUMH's Results Based Accountability plan [link to plan when posted]. Any metrics associated with potential audit findings were described in the Service, Satisfaction and Outcomes section above. All other metrics will be used to facilitate conversations, raise awareness and to help with goal setting.

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